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Rulings

Social Security Rulings

On Federal Old-Age
Survivors, Disability,
Supplemental Security Income;
and Black Lung Benefits

JAN 1982
SSR 82-1a to SSR 82-14

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Department of Health
and Human Services
Social Security Administration
Office of Operational Policy and Procedure
SSA Pub No. 65-002
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Preface

Social Security Rulings (the SSR) is published under the authority of the Commissioner of Social Security and makes available to the public a series of precedential decisions relating to Federal old-age, survivors, disability, supplemental security income, and black lung benefits programs. All reference to individual or specific businesses involved have been avoided so as not to disclose confidential information, unless already a matter of public record, as in a Federal court decision.

The SSR is based on case decisions, policy statements, decisions of the administrative law judges and the Appeal Council, opinions of the Office of the General Counsel, Commissioner's decisions, Federal court decisions, and other interpretations of the law and regulations. Once published, a ruling is binding on all components of the Social Security Administration in accordance with section 422.408 of Social Security Regulations No. 22 (20 CFR Part 422). Rulings do not have the force and effect of the law or regulations but are to be relied upon as precedents in determining other cases where the facts are basically the same. A ruling may be superseded, modified or revoked by later legislation, regulations, court decisions, or rulings.

Citations of a Social Security ruling may be made by reference to the ruling number and the issue in which it appears. For example, ruling number one for 1980 would be cited as SSR 80-1 (Jan. 1980), or SSR 80-1 (C.E. 1980) if the annual Cumulative Edition has been published. Rulings based on court decisions are identified by a suffic "c" (such as SSR 80-1c), and rulings based on a decision of the Appeals Council of the Office of Hearings and Appeals are identified by the suffix "a" (such as SSR 80-1a).

All references to sections of law relate to sections of the Social Security Act, as amended, unless otherwise specified. All references to regulations, unless otherwise specified, are to Social Security Regulations Nos. 1, 4, 10, 16, and 22. These appear in title 20 of the Code of Federal Regulations as Parts 401, 404, 410, 416 and 422. The Code, revised as of April 1981, is available through the U.S. Government Printing Office at a subscription price of $525. per year (single copies cost $8). New and amended regulations are first printed in the Federal Register; individual copies may be purchased for 75 cents.

The SSR is published quarterly—subscription price is $7.50 a year ($1.90 additional for foreign mailing); individual copies cost $2.25. An annual Cumulative Edition (formerly entitled the "Cumulative Bulletin") is published at the close of each calender year reproducing all rulings published throughout the year which have not been superseded. The cumulatives for the two most recent years are available for sale from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Those currently available are the 1979 edition ($4.00) and the 1980 edition ($5.50). All other cumulative editions from 1960 on are available to the public free of charge upon request to the Social Security Administration, Office of Regulations, 6401 Security Blvd., Baltimore, Maryland 21235.

Other related publications available for sale through the Government Printing Office are:

1. *Compilation of the Social Security Laws*—a copy of the Social Security Act, as amended, is available in a paper cover edition entitled "The Social Security Act and Related Laws." It includes parts of the Internal Revenue Code and other laws pertinent to the Social Security Act. Inquiries made to the Superintendent of Documents, U.S. Government Printing Office, will supply the user the date of the current edition available and its cost.
2. *The Social Security Handbook*—the sixth edition reflects the provisions of the Social Security Act as amended through March 1, 1978. The Handbook is intended for the use of people who want a detailed explanation of the various programs administered by the Social Security Administration, how they operate, who is entitled to benefits, and how benefits may be obtained. The Handbook is priced at $4.75 per copy. The seventh edition, scheduled for publication in the Spring of 1982, will be amended through December 31, 1981.

These publications, including materials now being prepared or planned, when published, may be obtained from the Superintendent of Documents, U. S. Government Printing Office, Washington, D.C. 20402. A check or money order covering the cost of the publication should accompany the order.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price: $2.25 per copy. Subscriptions: $7.50 a year; $1.90 additional for foreign mailing.

ERRATA
October 1981 Social Security Rulings

The following corrections should be made to the October 1981 quarterly issue of the SSR:

1. SSR 81-30, page 9, insert the following between the heading and the syllabus—

   "20 CFR 404.460 and 404.463 SSR 81-30
   (This supercedes SSR-78-12, C.B. 1978, p. 38)."

2. SSR 81-30, page 11, in the second paragraph change "202(t)(2)(b)" to read "202(t)(2)(B)" and in the last paragraph change "202(t)(2)(a)" to read "202(t)(2)(A)."

3. SSR 81-34c, page 21, footnote 4, change the first phrase in section 1611(e)(1)(B)(ii) to read "in case of an individual who has an eligible spouse" and delete the material in section 1611(e)(1)(B)(ii)(II) and replace it with "the applicable rate specified in subsection (b)(1) (reduced by the amount of any income, not excluded pursuant to section 1612(b), of the other); and."

READEX FICHE

1A
Rulings and Decisions

SECTION 202(d)(7)(D) and 204(a) and (b) (42 U.S.C. 402(d)(7)(D) and 404(a) and (b) CHILD'S INSURANCE BENEFITS—TERMINATION OF GRADUATE STUDENT'S ENTITLEMENT AT AGE 22— WAIVER OF RECOVERY—ACCEPTANCE OF BENEFITS AFTER NOTICE OF TERMINATION

SSR 82-1a

20 CFR 404.352(a)(1), 404.506, and 404.507

The claimant had received child's insurance benefits as a full-time student since January 1978. In July 1978, she completed a form regarding her expected student status as of October 1978, the month she would attain age 22. She reported that she had not yet completed the requirements for a degree from a four-year college or university but that she would attend graduate school in September 1978. Based on that information, the Social Security Administration (SSA) notified the claimant on August 10, 1978, that benefits would not be paid effective October 1978 because she would have completed the requirements for a degree from a 4-year university. On reconsideration, the claimant submitted evidence indicating she had not yet completed her requirements for graduation and was taking undergraduate courses which were required for teacher certification. Accordingly, SSA continued to pay benefits to the claimant through December 1978. On December 18, 1978, the university that the claimant had attended as an undergraduate informed SSA that the claimant had completed all the requirements for an undergraduate degree in June 1978. On December 20, 1978, SSA notified the claimant that she was not entitled to benefits as of October 1978. The claimant received her final check on January 3, 1979. *Held*, under section 202(d)(7)(D) of the Social Security Act (the Act), the claimant's entitlement to child's insurance benefits ended in September 1978, the month before she attained age 22 because she had completed all requirements for a degree from a four-year college or university at the time she attained age 22. *Further held*, the claimant was at fault in causing the overpayment for December 1978 because the record shows that she had accepted a benefit for that month after she was notified that the benefit was not due. Moreover, the record shows that the entire overpayment from October 1978 through December 1978 was incurred because of misleading information furnished by the claimant. Accordingly, the claimant was at fault in causing the overpayment and its recovery may not be waived.

The issue before the Appeals Council is whether the claimant was overpaid, and if so, the amount of the overpayment and whether recovery may be waived.

The claimant was born on October 5, 1956 and thus attained age 22 in October 1978. She had been entitled to child's insurance benefits on her father's record commencing with January 1978 based on an application she filed on November 23, 1977.

On July 29, 1978, the claimant completed a form supplied to students about to attain age 22 which is intended to indicate their expected student status when they reach age 22. This form was completed in a manner which gave contradictory information to the effect that the claimant had not yet completed the requirements for a degree from a four-year college or university but that she would be attending a graduate school beginning on September 27, 1978. Based on this report, SSA determined, and so advised the claimant by notice dated August 10, 1978, that her entitlement to benefits would not continue in October 1978 because she would have reached age 22 in that month and had completed the requirements for a degree from the 4-year university she attended.

The claimant filed a request for reconsideration on August 28, 1978, which stated that she was taking undergraduate courses which were required for teacher certification. At the same time, she submitted an application for candidacy for graduation which indicated that she had not met all the requirements for graduation. Upon reconsideration in September, SSA determined, based on that information indicating undergraduate status, that claimant was entitled to child's insurance benefits through December 1978, the end of the semester.

On December 18, 1978, SSA was notified by the university the claimant had attended as an undergraduate that the claimant had completed all requirements for a 4-year degree by June 3, 1978. Upon inquiry by SSA, the claimant corroborated the university's report. On that basis, SSA notified the claimant on December 20, 1978, that her entitlement to benefits had ended as of September 1978, the month before the month she attained age 22. On January 3, 1979, the claimant received the benefit payment for December.

Section 202(d)(1) of the Act provides for payment of benefits to a full-time student who has not yet attained age 22.

Section 202(d)(7)(D) of the Act provides, in pertinent part, that a child who attains age 22 and is still a full time student who has not completed the requirements for, or received a degree from, a four-year college or university shall be deemed not to have attained age 22 until the first day of the first month following the end of the quarter or semester in which he is enrolled at such time.

Section 204(a) of the Act provides, in part, that whenever an incorrect payment has been made, recovery or adjustment of the incorrect payment shall be made.

Section 204(b) of the Act and §404.506 of Regulations No. 4 provide that in any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery from, any person who is without fault if such adjustment or recovery would defeat the purpose of title II of the act or would be against equity and good conscience.

Section 404.507 of Regulations No. 4 provides, in part, that—"What constitutes fault . . . on the part of the overpaid individual . . . depends upon whether the facts show that the incorrect payment to the individual . . . resulted from:

(a) An incorrect statement made by the individual which he knew or should have known to be incorrect; or

(b) Failure to furnish information which he knew or should have known to be material; or

(c) With respect to the overpaid individual only, acceptance of a payment which he either knew or could have been expected to know was incorrect."

In a request for reconsideration of a determination on recovery of the overpayment, the claimant acknowledged that she had used the December 1978 benefit received on January 3, 1979, after being notified that she was not entitled to it. Thus, she is at fault in accepting that month's benefit. Additionally, it is the conclusion of the Appeals Council that the entire overpayment from October 1978 through December 1978 was incurred as a result of the misleading information supplied by the claimant. The instructions on the form that the claimant completed to continue benefits as of the month she attained age 22 clearly showed that continuing entitlement was possible only if she had not completed the requirements for, or received a degree from, a four-year college or university. When the claimant filed her reconsideration of August 1978, she supplied information which indicated that she was still an undergraduate student, but she did not indicate whether she had satisfied the requirements for a 4-year degree. For these reasons, the claimant was at fault in causing the overpayment from October 1978 through December 1978. Consequently, recovery of that overpayment may not be waived.

SECTIONS 203(b) and (f), 210(j), and 211(a) (42 U.S.C. 403(b) and (f), 410(j), and 411(a)) WORK REDUCTIONS—EARNINGS FROM SELF-EMPLOYMENT AS A SALES REPRESENTATIVE

20 CFR 404.415, 404.430, 404.1005, 404.1007, 404.1008(e), and 404.1080(a)

SSR 82-2

The claimant has received old-age insurance benefits since 1973, the year he became age 65, and his wife has received wife's insurance benefits on his earnings record since 1974. When the Social Security Administration (SSA) determined that the claimant had wages for deduction purposes in 1978 of $5,173.06 and that he and his wife had been overpaid $585.90 for that year due to his excess earnings, the claimant filed an appeal. The record shows that the claimant retired in 1973 and performed his subsequent sales activities on only a part-time basis beginning in 1976. *Held,* the claimant's testimony regarding the nature of his sales activities and the corroborating documentary evidence established that his 1978 income of $5,173.06 represented gross earnings from self-employment and not wages. The claimant's net earnings from self-employment, computed in accordance with sections 203(f)(5)(B) and 211(a) of the Social Security Act, were $3,438.43, an amount less than the applicable exempt amount of $4,000.00. As the claimant did not have excess earnings in 1978, he and his wife were not overpaid for that year.

The general issue is whether the claimant had excess earnings in 1978. This issue needs to be resolved to determine whether the claimant, who receives old-age insurance benefits, and his wife, who receives wife's insurance benefits on his earnings record, were overpaid in 1978.

The claimant, who was born on September 11, 1908, has received old-age benefits based on an application filed July 2, 1973, and his wife, who was born on October 12, 1912, has received wife's insurance benefits on his earnings record based on a application filed June 1, 1974. In 1979, the claimant and his wife were notified that an overpayment in the amount of $585.90 had been incurred on the claimant's earnings record because of his excess earnings in 1978. Specifically, SSA determined that the claimant's excess earnings resulted from his wages during 1978 in the gross amount of $5,173.06.

The claimant testified that he worked for a certain company as a products planner and sales liaison until his retirement on January 30, 1973. He explained that this activity did not involve selling, but that it did involve the role of liaison between the business and salespeople. He testified that, beginning in 1976, he became self-employed on a part-time basis as a sales representative for several companies, including the company he retired from in 1973. The claimant stated that he had to maintain an office in his home, purchase samples and office equipment, maintain secretarial services, and manage his schedule. He also reported that he received no benefits from his former employer, except for a retirement pension based solely upon his employment prior to his retirement in 1973. Finally, he explained that he held himself out to the business community as a representative of several business lines.

Section 203(b) of the Act provides that deductions "shall be made from any payment or payments under this title to which an individual is entitled, and from any payment or payments to which any other persons are entitled on the basis of such individual's wages and self-employment income, . . ." if the individual receives "excess earnings."

Section 203(f)(3) of the Act defines an individual's "excess earnings" as "50 per centum of his earnings for such year in excess of the product of the applicable exempt amount . . . multiplied by the number of months in such year . . . ." As provided in section 203(f)(8)(D)(i) of the Act, the applicable exempt amount for an individual who has attained age 65 before the close of a taxable year ending in 1978 is $333.33 1/3 for each month of that year. Therefore, if such an individual's taxable year is a calendar year, the individual will have excess earnings in 1978 if his or her earnings for that year exceed $4000 (12 × $333.33 1/3).

Section 203(f)(5)(A) of the Act states that "an individual's earnings for a taxable year shall be (i) the sum of his wages for services rendered in such year and his net earnings from self-employment for such year, minus (ii) any net loss from self-employment for such year."

Section 210(j) of the Act defines "employee" as (1) any officer of a corporation; or (2) an employee under the "usual common law rules;" (3) (A) an agent-or commission-driver, (B) a full-time life insurance salesman, (C) a home worker, or (D) "a traveling or city salesman . . . engaged upon a full-time basis in the solicitation on behalf of, and the transmission to, his principal (except for side-line sales activities on behalf of some other person) of orders from wholesalers, retailers . . . or other similar establishments for merchandise for resale or supplies for use in their business operations; if the contract of service contemplates that substantially all of such services are to be performed personally by such individual; except that an individual shall not be included in the term 'employee' under the provisions of this paragraph if such individual has a substantial investment in facilities used in connection with the performance of such services (other than in facilities for transportation), or if the services are in the nature of a single transaction not part of a continuing relationship with the person for whom the services are performed."

Section 211(a) of the act defines "net earnings from self-employment" as "the gross income, as computed under Subtitle A of the Internal Revenue Code of 1954, derived by an individual from any trade or business carried on by such individual, less the deductions allowed under such subtitle which are attributable to such trade or business . . . ."

Section 211(c) of the Act essentially defines "trade or business" with reference to Section 162 of the Internal Revenue Code of 1954.

Section 404.1008(e) of Regulations No. 4 provides that "If you take orders for a number of persons or firms as a 'multiple line' salesman, you are not a traveling or city salesman."

A common-law employee is described in §404.1007 of Regulations No. 4, which provides that -

"(a) *General . . .*

In general, you are a common-law employee if the person you work for may tell you what to do and how, when, and where to do it . . . .

(b) *Factors that show employee status . . .*

(1) The person you work for may fire you.
(2) The person you work for furnishes you with tools or equipment and a place to work.
(3) You receive training from the person you work for or are required to follow that person's instructions.
(4) You must do the work yourself.
(5) You do not hire, supervise, or pay assistants . . . .
(6) The person you work for sets your hours of work, requires you to work full-time, or restricts you from doing work for others.
(7) The person you work for pays your business or traveling expenses.
(8) You are paid by the hour, week or month.

(c) *Factors that show self-employment status . . .*

(1) You make a profit or suffer a loss.
(2) You are hired to complete a certain job and if you quit before the job is completed you may be liable for damages.
(3) You work for a number of persons or firms at the same time.
(4) You advertise to the general public that you are available to perform services.
(5) You pay your own expenses and have your own equipment and work place . . . ."

As indicated by the above provisions of the Act, an individual who was at least age 65 in 1978 was permitted to earn as much as $4,000 in that year before the amount of the benefits paid on his earnings record would be reduced because of "excess earnings." The claimant has alleged that his 1978 income of $5,173.06 represents gross earnings from self-employment, and he has asserted that reduction of that sum by his business expenses in the amount of $1,688.63 places his net self-employment income safely under the $4,000 exempt amount. Such a circumstance would necessarily eliminate the existence of excess earnings and the resulting overpayment for 1978.

Evaluation of the claimant's credible testimony and the corroborating documentary evidence satisfactorily establishes that the claimant's 1978 income resulted from self-employment and that his net income from that self-employment was safely under the $4,000 ceiling. With respect to the definition of an "employee" in section 210(j) of the Act, the claimant was not a corporate officer, agent- or commission-driver, or life insurance salesman. Nor was the claimant a "full-time" traveling salesman within the intent of that provision since he was a "multiple line" salesperson who took orders from several firms (see §404.1008(e) of Regulations No. 4). Finally, the claimant was not an "employee" under the common law rules because he furnished his own tools and work place, brought his expertise to the job and was not trained by a principal, and was not subject to specific direction by the businesses whose products he represented. The claimant set his own work hours, represented several businesses, and was not reimbursed for his business expenses. Unlike the traditional employee, his earnings were generated solely by his commission from sales; he was not guaranteed a minimum income; and he received no health or other noncommission benefit. The claimant held himself out to the public as an independent contractor for several business lines, and he retained secretarial services at his own expense and discretion.

The conclusion that the claimant was legitimately engaged in self-employment is corroborated by statements from knowledgeable corporate officials. Finally, this conclusion is consistent with the claimant's uncontested testimony that he retired in 1973 and has performed his subsequent sales activities on only a part-time basis since 1976.

Since the claimant's gross earnings in 1978 resulted from self-employment, sections 203(f)(5) and 211(a) of the Act requires reduction of that amount by the allowable deductions attributable to the business. Those deductions have been itemized and clearly and convincingly show that the claimant incurred $1,688.63 in allowable business expenses during 1978. Therefore, the claimant's net income from self-employment in 1978 was $3,484.43, which is less than the $4,000 exempt amount.

In view of the above findings, it is the decision of SSA that the claimant did not have excess earnings in 1978 and that an overpayment on his earnings record was not incurred in that year.

SECTION 210(j)(2) (42 U.S.C. 410(j)(2)—EMPLOYER-EMPLOYEE RELATIONSHIP—STATUS OF AIRLINE PILOTS

20 CFR 404.1007 **SSR 82-3c**

Selman v. Califano, 1A Unempl. Ins. Rep. (CCH) ¶ 17,474 (10th Cir 1980), 619 F. 2d 881

The claimant, who is a pilot for an airline, contended that he is an independent contractor and not an employee of the airline. He maintained that in flying an airplane he must exercise independent judgment and that the Federal Aviation Administration (FAA) rather than the airline controls how he flies the plane. It was found that use of independent judgment was characteristic of professional services but did not negate employee status unless the services were offered to the public in an independent business. Also, although FAA extensively regulates how the claimant is to fly a plane, the record shows that the airline retains the right to control the details of the claimant's work, subject to FAA regulations. In addition, claimant's earnings are based on a specified salary schedule rather than a profit or loss arrangement, claimant's investment in facilities is minimal; and there is a permanent relationship between the claimant and the airline. *Held*, there is substantial evidence to support the determination that the claimant is a common-law employee and therefore is an employee of the airline for purposes of the Social Security Act.

LOGAN, Circuit Judge:

Richard J. Selman, Jr., an airline pilot for Eastern Air Lines, contests his classification as an employee for purposes of the Social Security laws. The Social Security Administration (SSA) refused to rule that he was an independent contractor. After exhausting administrative remedies, Selman sought review in district court, which affirmed the SSA's determination and denied Selman's motion requesting a remand for the purpose of taking additional evidence.

Selman makes the following contentions in his appeal to this Court: (1) the SSA's findings are not supported by substantial evidence; and (2) the district court abused its discretion in denying the motion to remand for additional evidence. In addition, he has asked that our decision on his appeal be delayed until a new contract currently being negotiated between the Air Line Pilots Association and Eastern Air Lines (Eastern), can be submitted to this Court.

The applicable section of the Social Security Act, 42 U. S. C. §410(j) defines "employee" as anyone who has such a status under the "usual common law rules," referring to the master-servant concepts developed under the law of agency. A number of factors have been utilized in determining whether a person is an "employee" rather than an independent contractor. 20 C. F. R. §404.1004(c) states the main element of the test as employer right to control and direct not only the result to be achieved by the person, but also the means by which the result is achieved. The right to discharge and whether the employer furnishes the tools and the place of work are also important factors, indicative of an employer-employee relationship. *Id.* Other factors noted in *United States v. Silk*, 331 U. S. 704. [67 S. Ct. 1463, 91 L. Ed. 1757] (1947), are the opportunities for profit and loss, investment in facilities, permanency of the relationship between employer and worker, the skill required in doing the work and whether the service is an integral part of the employer's business. *Id.* at 716. No one factor is controlling, however, and the circumstances must be looked at in totality. *Id.* at 716, 719.

The evidence submitted at the admimistrative hearing is uncontroverted and consists mainly of the contract between Eastern and the Air Line Pilots Association.[1] The administrative law judge made the following pertinent findings of fact:

> 1. Eastern Air lines [sic], insofar as practicable, retains the right to control the details of the work performed for them by the claimant.
> 2. Claimant's earnings are not dependent on the profit or loss of Eastern Air Lines and are based on a specified salary schedule.
> 3. Claimant's investment in facilities is minimal and, in comparison with the investment of Eastern Air Lines, are of little significance.
> 4. There exists a permanent relationship between claimant and Eastern Air Lines.
> 5. The skills required in the performance of claimant's job are not such as to indicate either an employer-employee relationship or an independent contractor status.

These findings are supported by substantial evidence, as discussed below, and are therefore conclusive. See 42 U. S. C. §405(g). We also hold that these findings show employee status as a matter of law.

It is difficult to understand why Selman seeks reclassification to independent contractor status, which would push his social security taxes up to 8.1% from the current 6.13% on the first $25,900 of annual earnings. See I. R. C. §§ 1401, 3101. Nevertheless, he perists and attacks the findings of the SSA; we therefore deal with his contentions.

First, Selman emphasizes that in flying an airplane he must exercise independent judgment in many instances and otherwise the Federal Aviation Administration (FAA), not Eastern, controls how he flies the plane. The use of independent judgment, and the accompanying loss of some control by the employer, is a characteristic of all professional services. Professionals are not automatically excluded from employee status, however, unless they are engaged in an independent business in which they offer their services to the public. 20 C. F. R. §404.1004(c)(2). Selman does not fall into this category because he is prohibited by contract from flying professionally for anyone but Eastern and the national guard or military reserve.

Recognizing that special considerations are required in determining the status of professional persons, courts have found an employee relationship by virtue of the degree of control present in areas outside those in which professional judgment must be exercised. See *Cody v. Ribicoff*, 289 F. 2d

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[1] This contract was in effect from January 1975 through April 1977. The 1977 to 1979 contract was not entered into evidence at the administrative level, and the district court refused to remand for reconsideration in light of the new contract. That this specific contract is no longer in effect does not invalidate the evidence for our purposes on review.

394 (8th Cir. 1961) (doctor found an employee); *Flemming v. Huycke*, 284 F. 2d 546 (9th Cir. 1960) (same). The evidence here shows Eastern had the right to control most nonprofessional facets of the employment relationship. The contract contains the following provisions: Pilots cannot fly for others or engage in any business activities adverse to Eastern's interests; the number of hours a pilot can fly per month is limited; training and proficiency checks are required by Eastern and may exceed those required by the FAA; Eastern sets up the flight schedules and may require a pilot to take a flight when no pilot has bid for it; and Eastern can discipline and discharge a pilot, subject only to certain requirements of notice, hearing and appeal.

It is uncontroverted that the FAA extensively regulates how the pilot is to fly the plane. Since both the airline and the pilot are subject to the regulations, and therefore neither completely controls the means by which the job is accomplished, this fact is at least neutral. There is evidence, however, that Eastern retains the right to control the details of the work, subject to the FAA regulations.

An Eastern pilot's base pay is computed per hours of flying time; this amount is then varied according to the type of plane, the time of day, and the number of miles flown. A minimum monthly pay is guaranteed. Consequently, Selman's income is not directly affected by the profitability of his or the airline's activities. He can, of course, make more money by working more hours, but this is not "profit" in the sense that independent professionals profit by establishing fees that exceed their costs of providing services to clients or patients.

It is clear that Eastern furnishes the vast majority of the "tools" required by an airline pilot, and has made the investment in the aircraft and the terminal, booking and administrative facilities. Selman furnishes his own uniform, a flight bag and a tool kit, which are minimal by comparison. Although Selman has "invested" by obtaining training and a pilot's license, this is also true of essentially all people who work in a skilled occupation or profession, whether they serve as employees or independent contractors. Eastern also furnishes the place of work, the airplane; that it does not own, but leases, some airplanes and terminals is irrelevant.

There is extensive evidence that the relationship between Eastern and the pilots is contemplated as a permanent one. The contract provides for longevity pay rates, vacations, seniority provisions, leaves of absence, sick leave, promotions, life insurance and pension plans. These types of benefits are inconsistent with the one-job relationship existing between an employer and an independent contractor. That the pilots' contracts are usually for two-year terms does not affect the intended permanency of the relationship.

It is common sense that an airline pilot possesses a high degree of technical skill, but that skill is standard among all pilots. We agree with the administrative law judge that this factor is neutral.

The findings in favor of employee status, supported as they are by the record, provide a sound and unassailable basis for the employee classification. There can be no doubt that Selman would be considered the servant of Eastern under the common law rules referred to in 42 U. S. C. §410(j).

Selman filed a motion under 42 U. S. C. §405(g) in the district court for remand to consider the following additional information: a prospectus on

Eastern Air Lines Profit Sharing Plan; the 1977 to 1979 contract between Eastern and the Air Line Pilots Association; the FAA flight information and procedure manual; and a notification of a limited partnership available to employees for the purpose of owning an airplane leased to Eastern. The district court judge denied the motion because the evidence was merely cumulative. We have examined the proffered evidence and agree it is mostly cumulative and, to the extent it contains any new information, would not affect the result. Therefore, we affirm the denial as within the district court's discretion.

Selman has filed a motion in this Court requesting we delay consideration of his appeal until he can submit a copy of the new pilots' employment contract currently being negotiated with Eastern. He argues that the information this contract contains—additional wage variables for a pilot's ability to conserve fuel—is significant concerning the factor of whether he can profit from his own endeavors. This contract apparently is not yet a part of the employment relationship; at least it was not at the time of the motion. We must decide the appeal on the record made below. We cannot consider new evidence proffered at this level, except to determine whether the case should be remanded under 42 U. S. C. §405(g). The new contract, as represented to us, would not affect the result in this case. The motion to delay our consideration is denied.

The judgment is AFFIRMED.

SECTION 224 (42 U.S.C. 424) DISABILITY—REDUCTION OF BENEFITS DUE TO RECEIPT OF WORKMEN'S COMPENSATION—PAYMENTS UNDER THE VOLUNTEER FIREMEN'S BENEFIT LAW OF THE STATE OF NEW YORK

20 CFR 404.408 **SSR 82-4**

> To assure protection against loss of earning capacity, the Volunteer Firemen's Benefit Law (VFBL) of the State of New York provides payments to volunteer firemen who sustain injury in the line of duty. The VFBL benefits correspond to the maximum benefits paid under the State's workmen's compensation (WC) law. Also, applicable legislative history and court decisions indicate that the VFBL was intended as a particularized form of WC which takes into account the unique economic circumstances of volunteer firemen. *Held*, payments made under the VFBL of the State of New York are WC benefits subject to the offset provisions of section 224 of the Social Security Act (the Act).

A question has been raised regarding the treatment of payments made under the VFBL of the State of New York for purposes of the reduction provision under section 224 of the Act.

The VFBL was enacted to eliminate the confusion and lack of uniformity created by two overlapping New York State benefit programs; i.e., the General Municipal Law, which provides payments for "physical disability", and the Workmen's Compensation Law, which provides payments for "loss of earnings." The VFBL was enacted as a consolidation to provide payments for "loss of earning capacity" and, thus, takes into account the unique economic circumstances of volunteer firemen. In operation, VFBL benefits correspond to the maximum benefits paid under the State's WC law.

The legislative choice in making the VFBL a separate statute was one of convenient and equitable administration rather than the creation of a new or novel benefit program. This was the understanding of the then Governor of New York when he signed the bill into law. His Memorandum of Approval states at the outset that "[t]his bill, and a number of companion bills extend the coverage and benefits of workmen's compensation and, in the interests of recipients, simplify procedures whenever possible." It was also the understanding of the Joint Legislative Committee on Fire Laws which noted that the administration of VFBL by the Workmen's Compensation Board, and the incorporation of WC administrative procedures would ensure uniform construction of VFBL.

In an early application of VFBL, *Hausman v. Miller*, 178 N.Y.S. 2d 566 (S. Ct. 1958), the court found that the new law was intended to effectuate Article I, §18 of the New York Constitution, which authorized and describes WC. The court also stated that VFBL was "in effect, a 'baby-brother' Workmen's Compensation Law, designed to assure to the volunteer fireman protection against loss of earning power through injury sustained in line of duty, irrespective of fault."

A more recent case, *Pollini v. Fuller Road Fire Department*, 321 N.Y.S. 2d 411 (S. Ct. 1971), aff'd. 331 N.Y.S. 2d 7342, 357 N.Y.S. 2d 502, reaches the same conclusion. There, the Court stated that "a reading of the VFBL impels the conclusion that it was the intent of the legislature in enacting this statute to follow the purport and objectives of the Workmen's Compensation Law."

Section 224 of the Act provides for the reduction of benefits based on disability on account of the receipt of WC. Although not denominated as such, VFBL is merely a particularized form of WC created by the New York legislature to accommodate the needs of persons who perform a vital but unpaid function. Therefore, payments made under the VFBL of the State of New York are WC for purposes of section 224(a) of the Act.

SECTION 224 (42 U.S.C. 424) DISABILITY—REDUCTION OF BENEFITS DUE TO RECEIPT OF WORKMEN'S COMPENSATION—TREATMENT OF CERTAIN LUMP-SUM SETTLEMENTS MADE UNDER NEW JERSEY LAW

20 CFR 404.408 **SSR 82-5**

Under the conditions described in section 34:15-20 of the New New Jersey statute, the State's Division of Workers' Compensation may approve a lump-sum settlement arising from a claim for compensation following an employee's accident, injury, or occupational disease. Such a settlement has "the force and effect of a dismissal of the claim petition" and is "a complete surrender of any right to compensation" under the State's workmen's compensation (WC) statutes. The New Jersey statute provides that any payments made under section 34:15-20 are to be recognized as WC benefits solely for insurance rating purposes. *Held*, the State's characterization of the payments is not binding on the Social Security Administration. The lump-sum settlements under section 34:15-20 of the New Jersey statute are made in lieu of periodic benefits and thus are WC benefits subject to the offset provisions of section 224 of the Social Security Act.

A question has been raised whether the lump-sum settlements discussed in section 34:15-20 of the New Jersey statute are WC benefits subject to the offset provisions of section 224 of the Social Security Act (the Act).

Section 34:15-20 of the New Jersey statute states:

> "In case of a dispute over or failure to agree upon a claim for compensation between employer and employee, or the dependents of the employee, either party may submit the claim, both as to the questions of fact, the nature and effect of the injuries, and the amount of compensation therefore according to the schedule herein provided, to the Division of Workers' Compensation, as prescribed in article 4 of this chapter (section 34:15-49 et seq.). After a petition for compensation or dependency claims has been filed, seeking compensation by reason of accident, injury or occupational disease of any employee, and when the petitioner is represented by an attorney of the State of New Jersey, and when it shall appear that the issue or issues involve the question of jurisdiction, liability, casual relationship or dependency of the petitioner under this chaper, and the petitioner and the respondent are desirous of entering into a lump-sum settlement of the controversy, a judge of compensation may with the consent of the parties, after considering the testimony of the petitioner and other witnesses, together with any stipulation of the parties, and after such judge of compensation has determined that such settlement is fair and just under all the circumstances, enter 'an order approving settlement.' Such settlement, when so approved, notwithstanding any other provisions of this chapter, shall have the force and effect of a dismissal of the claim petition and shall be final and conclusive upon the employee and the employee's dependents, and shall be a complete surrender of any right to compensation or other benefits arising out of such claim under the statute. Any payments made under this section shall be recognized as payments of workers' compensation benefits for insurance rating purposes only."

Section 224(b) of the Act provides:

> "If any periodic benefit under a WC law or plan is payable on other than a monthly basis (excluding a benefit payable as a lump sum except to the extend that it is a cummutation of, or a substitute for, periodic payments), the reduction under this section shall be made at such time or times and in such amounts as the Secretary finds will approximate as nearly as practicable the reduction when benefits are payable on a monthly basis."

Although the last sentence of section 34:15-20 of the New Jersey statute states that payments made under that section are to be recognized as WC benefits solely for insurance rating purposes, this characterization is not binding on SSA. In the absence of a plain indication to the contrary, it will be assumed that the application of a Federal statute is not dependent on State law. This assumption is based on the need for nationwide uniformity of application of Federal law. In addition, Federal programs may be impaired if State law was controlling. For example, in a claim brought in New York under title VII of the Civil Rights Act of 1964 (see, *Popkin v. N.Y. Dept. of Health and Mental Hygiene*, 547 F. 2d 18, 19 (2d Cir 1976)), the court applied the above rule and stated that terms used, but not defined in that Act would not be construed according to New York law because title VII does not provide that the terms of the Federal statute are to be construed according to State law.

The same result is reached in the present situtation. Unlike certain provisions of the Act which specifically mandate that State law is to be controlling, section 224 of the Act makes no reference to State law. Therefore, section 34:15-20 is not controlling. Although the final sentence in section 34:15-20 of the New Jersey statute is not binding for purposes of section 224 of the Act, this does not mean that the State law is of no importance. It is the actual "nature and purposes" of the payment rather than the words used to describe it which are ultimately controlling (see Larson, The Law of *Workmen's Compensation,* III, §97.34 (1973 ed)). State law is of great importance in determining the "nature and purposes" of the particular benefit payment at issue.

For example, section 34:15-20 of the New Jersey statute is contained in the "Labor and Workmen's Compensation" Title of the New Jersey Code. In the language of section 34:15-20 itself, the lump-sum settlement arises when there is a "dispute over or failure to agree upon a claim for compensation between employer and employee...", and compensation is being sought for "accident, injury or occupational disease." The settlement is submitted to and approved by the Division of Workers' Compensation, which has exclusive jurisdication of all claims for worker's compensation benefits. Most importantly, section 34:15-20 settlements have "the force and effect of a dismissal of the claim petition" and are "a complete surrender of any right to compensation" under the WC statutes. Thus, the lump-sum settlements are made in lieu of periodic payments. The above evidence that these lump-sum settlements are WC benefits subject to the offset provision of section 224(a) of the Act is sufficient to counter the statement to the contrary in section 34:15-20 of the New Jersey statute.

SECTIONS 1611(a)(1)(B) and 1613(a)(42 U.S.C. 1382(a)(1)(B) and 1382(a)) SUPPLEMENTAL SECURITY INCOME—NONEXCLUDABLE RESOURCES—PROPERTY AGREEMENTS

20 CFR 416.1201, 416.1220, and 416.1224(a) **SSR 82-6**

The claimant applied for supplemental security income (SSI) benefits in January 1980. When the Social Security Administration (SSA) determined that a contract for deed, which the claimant has owned since selling certain real property in 1972, was a countable resource with a value of $3,950, it denied the claimants's application because her resources exceeded the statutory limit. Consequently, the claimant filed an appeal, contending that her interest in the property was a nonliquid resource which should be excluded under 20 CFR 416.1224(a) as property essential to self-support. The contract for deed meets the definition of a liquid resource in 20 CFR 416.1201(b) and may be converted to cash within 20 work days.[1] In the case of nonbusiness property, 20 CFR 416.1220 provides that the exclusion of property essential to self-support does not apply to liquid resources, even if they are producing income. *Held*, the contract for deed is a countable resource and its value exceeds the statutory limit; therefore, the claimant is ineligible for SSI benefits.

It has been determined that the claimant meets all factors of eligibility for SSI benefits except with respect to the question of her resources. Accordingly, the issue is whether the claimant's resources, other than resources excluded pursuant to section 1613(a) of the Social Security Act (the Act), are not more than $1,500 as provided in section 1611(a)(1)(B)(ii) of the Act. The specific issue to be determined is whether the outstanding balance on a contract for deed is a countable resource for determining the claimant's eligibility for SSI benefits.

The claimlant filed an application for SSI benefits on January 11, 1980. Her request was initially denied on February 14, 1980, because of excess resources. Following a request for reconsideration, the claimant's application was again denied on February 22, 1980. The claimant then requested a hearing before an Administrative Law Judge.

The evidence of record in this case indicates that on August 10, 1972, the claimant executed a contract for deed for the sale of certain real property. The purchase price of the property was $8,000. The buyers made a down payment of $800 upon execution of the contract for deed and the arrangements for the balance read as follows: "$55.84 on October 1, 1972, and $55.84 on the first day of each month thereafter until October 1, 1982, on which date the entire unpaid balance due hereunder shall become due and payable in full, with interest from September 1, 1972, on the unpaid balance from time to time at the rate of 7% per annum, payable monthly, with and as part of said monthly installment payments, said monthly installment payments to include both principle and interest and said payments shall be applied first to the payment of the interest due on the first day of each and every month, and the remainder in reduction of the principle." As of the date of the claimant's application for SSI benefits, the outstanding balance on the contract for deed was $5,637.22. A letter from a bank, dated January 9, 1980, indicated that the bank would buy the contract for deed, if offered, for $3,950. This valuation appears consistent with the claimant's equity in the contract for deed.

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[1] SSR 79-12 (C.E. 1979) provides that liquid resources are those properties that are in cash or are financial instruments which are convertible to cash within 20 work days. [ED]

The claimant's attorney has presented a written argument on her behalf in which she argues that the claimant's interest in the property in question should be considered a nonliquid resource which should be excluded in determining the claimant's eligibility for SSI benefits as a property essential to her self-support.

Section 1611(a)(1) of the Act provides, in part, that each aged, blind, or disabled individual "...whose resources, other than resources excluded pursuant to section 1613(a), are not more than...$1,500, shall be an eligible individual for purposes of this title."

Section 1613(a)(3) of the Act excludes from an individual's resources "other property which, as determined in accordance with and subject to limitations prescribed by the Secretary, is so essential to the means of self-support of such individual...as to warrant its exclusion."

Section 416.1201(a) of Regulations No. 16 defines "resources" as cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his support and maintenance. If the individual has the right, authority or power to liquidate the property, or his share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).

Section 416.1201(b) of Regulation No. 16 defines "liquid resources" as those assets that are in cash or are financial instruments which are convertible to cash. Liquid resources include cash on hand, cash in savings accounts or checking accounts, stocks, bonds, mutual fund shares, promissory notes, mortgages, and similiar properties.

Section 416.1201(c) of Regulations No. 16 defines nonliquid resources as all other properties. The term includes both real and personal property.

Section 416.1220 provides that the exclusion of property essential to self-support applies to both property used in a trade or business and to property not used in a trade or business. In the case of property not used in a trade or business, however, the exclusion does not apply to liquid resources, even if they are producing income.

Section 416.1224(a) of Regulations No. 16 provides for the exclusion of nonliquid property which although not used in a trade or business is essential to the individual's self-support.

The argument presented by the claimant's counsel has not persuaded SSA that the claimant's contract for deed is a nonliquid resource to be excluded under §416.1224(a) of Regulations No. 16 as a property essential to her self-support. The contract for deed meets the definition of a liquid resource in §416.1201(b) of Regulations No. 16 because SSA considers property liquid in nature if it can be converted to cash within 20 work days. The bank, in its letter of January 9, 1980, has reinforced the liquidity of the contract for deed by expressing a willingness to purchase it. Section 416.1220 of Regulations No. 16 specifically provides that, in the case of nonbusiness property, the exclusion of property essential to self-support does not apply to liquid resources, even if they are producing income. Hence, the contract for deed is a countable resource and its value exceeds the $1,500 statutory limit; consequently, the claimant is ineligible for SSI benefits.

SECTIONS 1611(a)(1)(B) and 1613 (a) (42 U.S.C. 1382(a)(1)(B) and 1382b(a)) SUPPLEMENTAL SECURITY INCOME—NONEXCLUDABLE RESOURCES--ANTIQUES AND HEIRLOOMS

20 CFR 416.550, 416.553(a), 416.554, 416.1201, 416.1205(a), 416.1210(b), and 416.1216 SSR 82-7

The claimant received supplemental security income (SSI) benefits from August 1977 through June 1979 totaling $3,160.40. The Social Security Administration (SSA) subsequently determined that the claimant was ineligible for those benefits because her countable resources had exceeded the statutory limit. When SSA notified her that she had been overpaid, the claimant appealed. During the period in question, the claimant owned antiques and heirlooms which she had inherited from her parents' estate. Although the market value[1] of these items was $10,000, the claimant was reluctant to dispose of them because of their sentimental value. *Held*, the antiques and heirlooms were resources because, under 20 CFR 416.1201(a), the claimant could have converted them to cash for her support and maintenance. *Further held*, under 20 CFR 416.1216(b), the amount by which the total market value of the claimant's household goods and personal effects, including her antiques and heirlooms, exceeded $1,500[2] was counted against the resource limitation; consequently, the claimant was ineligible for SSI benefits because her countable resources exceed the statutory limit. *Further held*, although the claimant was without fault in creating the overpayment, the record shows that its recovery would neither defeat the purpose of title XVI nor be against equity or good conscience; therefore, recovery of the overpayment may not be waived.

The general issue is whether the claimant was eligible for the SSI benefits paid to her from August 1977 through June 1979. The specific issues are whether the claimant's countable resources exceeded the statutory limit during that period and, if so, whether the incorrect payments made to her are subject to waiver.

The claimant was awarded SSI benefits, effective August 1, 1977, based upon an application dated August 30, 1977. On June 11, 1979, she was notified that she was ineligible for these benefits because she had (during all relevant times) been in possession of resources in excess of the statutory limit. Accordingly, SSA determined that the claimant had been overpaid SSI benefits from August 1977 through June 1979 in the amount of $3,160.40 and held that, even though she had been without fault in causing the overpayment, recovery could not be waived. The claimant requested reconsideration, and on February 29, 1980, the prior determination was affirmed. Being dissatisfied, the claimant filed a Request for Hearing on April 3, 1980.

At her hearing, the claimant did not contest that during all relevant times she had been the owner of certain items which had a market value well in excess of $1,500.00. However, the claimant was of the opinion that these items should never have been included in her list of "resources" because they are antiques and heirlooms which she received from her parents' estate and, as such, cannot be sold for sentimental reasons.

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[1] The current regulations at 20 CFR 416.1201(c), which became effective on November 1, 1979, provide that resources are evaluated according to their equity value. The prior regulations, also at 20 CFR 416.1201(c), provided that resources were evaluated according to their current market value.

[2] The current regulations, also at 20 CFR 416.1216(b), provide for a household goods and personal effects exclusion of $2,000. This new amount became effective on November 1, 1979.

Section 416.1201 of Regulations No. 16 provides that:

> "...resources mean cash or other liquid assets or any real or personal property that an individual...owns and could convert to cash to be used for his support and maintenance. If the individual has the right, authority or power to liquidate the property, or his share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual....
>
> "Nonliquid resources include all other properties. The term includes both real and personal property. Nonliquid resources are evaluated according to their current market value except as otherwise provided....
>
> "...the 'current market value' of an item is defined as: ...the price that item can reasonably be expected to sell for on the open market in the particular geographic area involved."[3]

Section 416.1205(a) of Regulations No. 16 provides that:

> "An aged, blind, or disabled individual with no spouse shall be eligible for benefits under title XVI of the Act if his nonexcludable resource do not exceed $1,500 and all other eligibility requirements are met...."

Section 416.1210 of Regulations No. 16 provides, in part, that:

> "In determining the resources of an individual (and spouse, if any), the following items shall be excluded...
>
> (b) Household goods and personal effects to the extent that their total value does not exceed the amount provided in §416.1216...."

Section 416.1216 of Regulations No. 16 provides that:

> "Household goods are defined as including household furniture, furnishings and equipment which are commonly found in our about a house and are used in connection with the operation, maintenance and occupancy of the home. Household goods would also include the furniture, furnishings and equipment which are used in the functions and activities of home and family life as well as those items which are for comfort and accommodation. Personal effects are defined as including clothing, jewelry, items of personal care, individual education and recreational items such as books, musical instruments, and hobbies. In determining the resources of an individual...household goods and personal effects are excluded if their total market value is $1,500 or less. If the total market value of household goods and personal effects in in excess of $1,500, the excess is counted against the resource limitation...."[4]

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[3] See footnote 1.

[4] See footnote 2.

Section 416.550 of Regulations No. 16 provides, in pertinent part, that:

"Waiver of adjustment or recovery of an overpayment of supplemental security income benefits is applicable...when:

(a) The overpaid individual was without fault in connection with an overpayment, and

(b) Adjustment or recovery of such overpayment would either:
  (1) Defeat the purpose of title XVI, or
  (2) Be against equity or good conscience...."

Section 416.553(a) of Regulations No. 16 provides that:

"We consider adjustment or recovery of an overpayment to defeat the purpose of the supplemental security income (SSI) program if the individual's income and resources are needed for ordinary and necessary living expenses...."

Section 416.554 of Regulations No. 16 provides that:

"Adjustment or recovery is considered to be inequitable and contrary to good conscience when such person, in reliance on such payments or on notice that such payment would be made relinquished a valuable right or changed his position for the worse. In making such a decision, the individual's financial circumstances are not considered...."

In the instant case, it is clear that SSA had acted properly when it included the claimant's heirlooms and family antiques in her list of "resources", and determined that she was ineligible for the payment of SSI benefits because those items had (during all relevant times) a market value far in excess of $1,500.00.

Even though the claimant was reluctant to liquidate these resources because of their sentimental value, there can be no doubt that she has always had the "right, authority or power" to convert them to cash so that they could be used for her support and maintenance. Furthermore, a recent appraisal of these particular personal effects (which include an antique dresser, desk, and commode, as well as a 12 place-setting of sterling silver) has established their value at $10,000. Thus, even after using the $1,500 exclusion set forth in §416.1216 of Regulations No. 16,[5] it is clear that the market value of those items exceeded by $7,000 the ceiling placed upon allowable resources under §416.1205 of Regulations No. 16.

SAA had previously determined that the claimant was without fault in the creation of the overpayment of SSI benefits in the amount of $3,160.40. The claimant was unaware that her heirlooms and antiques were countable as "resources" and that their value, which exceeded the maximum allowable under the Act, made her ineligible for SSI benefits. However, recovery of the overpayment was not waived because it was determined that such recovery would neither defeat the purpose of title XVI nor be against equity or good conscience.

Again, the total evidence in this case supports the finding that SSA acted properly when it refused to waive recovery of the overpayment.

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[5] See footnote 2.

It has already been established that the claimant owns certain resources with a value of $10,000 and that she has the right, authority, and power to liquidate those resources in order to provide for her support and maintenance.

Section 416.553(a) of Regulations No. 16 provides that recovery of overpaid benefits will defeat the purpose of title XVI of the Act if such recovery would deprive the overpaid individual of income or other resources required for ordinary and necessary living expenses. In light of the value of the claimant's heirlooms and antiques, it is thus clear that recovery of the overpayment in this case would not defeat the purpose of title XVI of the Act.

Section 416.554 of Regulations No. 16 provides that recovery of over paid benefits will be against equity and good conscience if, because of notice that such payments would be made or by reason of the incorrect payments, the overpaid individual relinquished a valuable right or changed his position for the worse. In the instant case, neither has occurred.

SECTION 1611(f) (42 U.S.C. 1382(f)) SUPPLEMENTAL SECURITY INCOME—SUSPENSIONS DUE TO ABSENCE FROM THE U.S.

20 CFR 416.1327 **SSR 82-8**

R, a Supplemental Security Income (SSI) recipient, left the United States (U.S.) on July 2, 1980, and returned on August 2, 1980. The Social Security Administration (SSA) determined that, under 20 CFR 416.1327(a), R was ineligible for SSI benefits for August 1980 and that her eligibility resumed beginning September 1980 when she again met all eligibility requirements. R appealed the determination regarding her ineligibility for August 1980. 20 CFR 416.1327(a) provides that a recipient is ineligible for SSI benefits beginning with the first full calendar month he or she is "outside the U.S." It further provides that after a recipient has been "outside the U.S." for 30 consecutive calendar days, the recipient is considered as remaining "outside the U.S." until he or she has returned to and remained in the U.S. for a period of 30 consecutive calendar days. *Held,* R was ineligible for SSI benefits for August 1980 because, under 20 CFR 416.1327(a), she is considered to have been "outside the U.S." for that entire month.

The general issue is whether R is eligible for an SSI benefit for the month of August 1980. The specific issue is whether the claimant was "outside the U.S." for a period of 30 consecutive days. If so, then she would be ineligible for SSI benefits beginning with the first full calendar month that she was outside the U.S.

On July 2, 1980, R, an SSI recipient, informed SSA that she was leaving the U.S. She stated the following in writing: "I should not be gone more than 30 days. I will report when I come back." R then left the U.S. at 9:00 PM on July 2, 1980, and returned on August 2, 1980, at 5:00 PM. During the intervening 30 full 24-hour calendar days, R was in the Philippine Islands.

SSA determined that, under section 1611(f) of the Social Security Act and §416.1327(a) of the regulations, R was ineligible for SSI benefits for August 1980 and her eligibility resumed beginning September 1980 when she again met all eligibility requirements. R appealed the determination regarding her ineligibility for August 1980.

In her statements in the record and at the hearing, R asserted that she notified an SSA claims representative of the dates of her travel and was informed that she would remain eligible for SSI benefits. R does not remember the name of the claims representative nor does she remember her written statement of July 2, 1980. R also testified that the statement on her request for reconsideration, dated August 19, 1980, that she was unable to get an airplane reservation on August 1, 1980, was incorrect.

R contended that it was unfair to penalize her by withholding one month's payment when she could have arranged travel times to comply with the 30 day requirement if it had been explained to her upon her inquiry at the Social Security office.

Section 416.1327(a) of the regulations provides that "A recipient is ineligible for benefits beginning with the first full calendar month he is outside the United States, and his payments are subject to suspension for such month...after a recipient has been outside the United States for 30 consecutive calendar days, he is considered as remaining outside the United States until he has returned to and remained in the United States for a period of 30 consecutive days. Each calendar day consists of a full 24-hour day."

Under §416.1327(a) of the regulations, R is considered to have been "outside the U.S." from July 2, 1980, until September 1, 1980 (i.e., R was actually out of the United States only from July 2 to August 2. That time period included 30 consecutive days. Because she was actually outside the United States for 30 consecutive days, under the regulations she was still considered to be outside the United States for the 30 consecutive days she remained in the U.S. after her return. Thus, she was considered as being outside the United States from July 2 until September 1.) Therefore, she was ineligible for SSI benefits for August 1980 because she is considered to have been "outside the U.S." for that entire month.

SECTION 1612(a)(2)(A) (42 U.S.C. 1382(a)(2)(A)) SUPPLEMENTAL SECURITY INCOME—IN-KIND UNEARNED INCOME—REDUCTION OF BENEFITS DUE TO RECEIPT OF A RENTAL SUBSIDY—CONSTITUTIONALITY

20 CFR 416.1145(a) and 416.1146(k)* **SSR 82-9c**

Smith, Griffin, & Johnson v. Califano, U.S.D.C., Oregon, Civ. Nos. 76-875, 76-936, and 76-937 (7/19/77)

The Social Security Administration (SSA) reduced the plaintiffs' supplemental security income (SSI) payments because they had received free or subsidized housing from their children. The plaintiffs alleged that the statute and regulations which provide for this reduction resulted in irrational classifications because SSI receipients who pay little or no rent and (1) receive public housing assistance, or (2) own their own homes, or (3) reside with a homeowner and share household expenses do not have their benefits reduced. The plaintiffs argued that the statute and regulations involved are therefore unconstitutional. In reaching its decision, the court applied the standard that statutes and regulations are not unconstitutional unless they manifest a patently arbitrary classification lacking in rational justification. Here the court found that Congress could rationally have concluded that the exclusions accorded to SSI recipients who receive public assistance, are homeowners, or reside with a homeowner and share household expenses further legitimate statutory goals. Consequently, in affirming the determinations reducing the plaintiffs' benefits, the court *held* (1) that the challenged classifications are not unconstitutional because they are neither patently arbitrary nor irrational and (2) that the lack of similar exclusions for the plaintiffs' class does not deny them equal protection under the law.

BELLONI, District Judge:

Plaintiffs bring their actions pursuant to Sections 205(g) and 1631(c)(3) of the Social Security Act, 42 U.S.C. §§405(g) and 1383(c)(3), to obtain judicial review of final decisions of the Secretary of Health, Education, and Welfare which reduced their supplemental security income (SSI) benefits under Title XVI of the Social Security Act, 42 U.S.C. §1381, et seq. All parties now move for summary judgment.

Under the SSI program, the amount of benefits allocated to a recipient is reduced by the amount of countable income he or she receives, 42 U.S.C. §1382(b)(1). Countable income is defined as both earned and unearned income and includes "support and maintenance furnished in cash or kind," 42 U.S.C. §1382a(a)(2)(A). In the instant cases, plaintiffs' benefits were reduced by the amount of support they received from their children and grandchildren in the form of housing provided for little or no rent. Plaintiffs seek to have those parts of the statute and regulations which mandate this result declared unconstitutional, and the decision of the Secretary based on them reversed. As the three cases involve the idential issue, they have been consolidated for hearing.

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*The regulations used to determine income under title XVI of the Social Security Act were recodified effective October 3, 1980. See 45 FR 65541-65559 (1980) (to be codified in 20 CFR 416.1100-416.1182). The provisions of the regulation cited in this Ruling have been rewritten as part of the recodification, but not substantively changed, and now appear in §416.1124(b) at 45 FR 65550 and in II(c)(1) of the Appendix at 45 FR 65558.

Plaintiffs predicate their constitutional attack on the existence of certain allegedly irrational classifications created by the statute and regulations. Plaintiffs contrast the fact that their benefits were reduced for receiving free or subsidized housing from their offspring with the fact that other SSI recipients who pay little or no rent do *not* have their benefits reduced. Plaintiff points to three such "favored" groups of SSI recipients:

1. Those who receive public housing assistance;
2. Those who own their own homes free and clear;
3. Those who reside with a homeowner and share household expenses.

The standard for testing the constitutional validity of a classification under the Social Security Act was clearly stated in *Fleming v. Nestor,* 363 U.S. 603, 611 (1960):

> "Particularly when we deal with a withholding of a noncontractual benefit under a social welfare program such as [Social Security], we must recognize that the Due Process Clause can be thought to interpose a bar only if the statute manifests a patently arbitrary classification, utterly lacking in rational justification."

See also *Weinberg v. Salfi,* 422 U.S. 749 (1975).

For the reasons given below, I find that the challenged classifications are neither "patently arbitrary" nor "utterly lacking in rational justification."

The exclusion accorded public housing rent subsidy recipients under the SSI program is found in 20 C.F.R. §§416.1145 and 416.1146(k). These sections require that payments or benefits provided under a federal statute be excluded from countable unearned income where exclusion is required by the granting statute. The statute pertinent to this case, providing for the exclusion of certain housing subsidies under Section 23 of the United States Housing Act of 1937, 42 U.S.C. §4121B, is §9 of Public Law 92-213 (1971). I find that Congress could rationally have concluded that this exclusion furthered the legitimate goal of effectuating the purposes of the federal public housing program.

As to that class of SSI recipients who own their own homes, 42 U.S.C. §1382b provides that the value of the home is excluded under the resource exclusions section. I find that Congress could rationally have concluded that the exclusion was appropriate in order to avoid disincentives to home ownership, thereby furthering the statute's goals of encouraging self-support.

Finally, §12236.3 of the Claims Manual provides that the reduction of SSI benefits will not apply to those recipients who reside with a homeowner and share household operating expenses. I find that Congress could rationally have concluded that the granting of an exclusion to those who enter into a "sharing" arrangement furthered one of the purposes of the statute of encouraging recipients to look to private sources of support. In this regard, it is worth noting that the House Committee on Ways and Means recently noted its approval of the Social Security Administration's policy on sharing arrangements, House Report No. 94-1201, May 27, 1976, page 11.

The fact that no similar exclusions were granted plaintiffs' class does not result in a denial of equal protection. As the Supreme Court noted in *Jefferson v. Hackney:*

> "A legislature may address a problem 'one step at a time,' or even 'select one phase of a field and apply a remedy there, neglecting the other,' *Williamson v. Lee Optical Co.*, 348 U.S. 483, 489 (1955)" 406 U.S. 535, 546 (1972).

The Court continued:

> "So long as its judgments are rational, and not invidious, the legislature's efforts to tackle the problems of the poor and the needy are not subject to a constitutional straitjacket. The very complexity of the problems suggests that there will be more than one constitutionally permissible method of solving them," 406 U.S. at 546.

As I find that the challenged classifications are rational, defendant's motions for summary judgment should be granted and the decisions of the Secretary should be affirmed. Plaintiffs' motions for summary judgment should be denied.

SECTION 1614(a)(3)(E) (42 U.S.C. 1382c(a)(3)(E) SUPPLEMENTAL SECURITY INCOME—CONTINUANCE OR CESSATION OF A GRANDFATHEREE'S DISABILITY—A RULING OF NON-ACQUIESCENCE

20 CFR 416.994(e) **SSR 82-10c**

Finnegan v. Matthews, 641 F. 2d 1340 (1981)

The Social Security Administration (SSA) does not acquiesce in the court's decision.

The claimant, who had been receiving State disability welfare payments since 1972, was grandfathered into the Supplemental Security Income (SSI) program on January 1, 1974. Section 1614(a)(3)(E) of the Social Security Act (the Act) provides for the continued payment of SSI benefits to a grandfatheree who "is permanently and totally disabled as defined under a State plan...so long as he is continuously disabled as so defined." Following a continuing disability investigation, SSA determined that the claimant's SSI benefits would terminate because he did not meet the requirements for entitlement at the time of the continuing disability investigation. This determination was affirmed by the district court.

The court of appeals, however, reversed SSA's determination. It found that SSI disability benefits to a grandfatheree may not be terminated unless SSA shows that there was either a material improvement in the grandfatheree's medical condition or a clear and specific error in the prior State determination. Because neither of those conditions was shown by SSA to be met, the court held that SSA's termination of the claimant's SSI benefits was improper.

SSA believes that the court's standard for determining whether SSI disability benefits to a grandfatheree should terminate would be impossible to administer and that the correct standard for making such a determination is in 20 CFR 416.994(e); i.e., that disability of a grandfatheree terminates when his or her "disability as shown by current medical or other evidence does not meet the criteria of the appropriate State plan" and does not meet the Federal criteria. Many grandfatherees were on State disability rolls for years before conversion, and the evidence on which they were originally allowed may not be available, or may not even exist. Therefore, in those cases, SSA could not possibly prove either "material improvement" or "clear and specific error" in the prior State determination. Thus, under 20 CFR 416.994(e) the grandfatheree properly remains in SSI benefit status only until it is found that the grandfatheree's disability, as shown by current medical or other evidence, meets neither the State nor Federal definition of disability. SSA believes that this regulation is fully consistent with the requirements of section 1614(a)(3)(E) of the Act and with congressional intent.

Consequently, SSA *holds* that the standard in 20 CFR 416.994(e), and not the one set forth by the court, should apply in determining whether the disability of a title XVI grandfatheree has ceased.

GOLDBERG, Circuit Judge:

This case presents the novel problem of interpreting a grandfather clause authored by Congress as part of its 1972 rewriting of sections of the Social Security Act ("Act"). Defendant, the Secretary of Health, Education and Welfare (hereinafter "Secretary" or "HEW"), seeks to rely on its own regulations, written after the passage of the Act, to read the prose of congressional Magi as those of legislative Indian givers, and to interpret a wise, fair grandfather clause as a grizzly, old miser. Because we find this Scrooge-like transmogrification of the clause to be inconsistnet with its plain meaning and legislative history, with subsequent intimations by the judicial readership, and with the dicates of both policy and common sense, we reject the position of the Secretary.

I. *PORTRAIT OF A GRANDFATHER: THE CLAUSE*

In October, 1972, Congress repealed the categorical assistance program (Title XIV of the Social Security Act) which had provided federal grants to state-administered disability assistance programs. 42 U.S.C.A. §§ 1351-1355, Pub. L. No. 92-603, 86 Stat. 1484 § 303 (repealed 1972). At the same time, Congress established a program identified as Supplemental Security Income for Aged, Blind and Disabled ("SSI"), which became effective in January 1974. 42 U.S.C.A. §§ 1381-1383 (West 1974). Under the federally-administered SSI program, the federal government assumed the burden of providing benefits directly to those needy people who were "disabled" as defined in the Act. 42 U.S.C.A. § 1381 (West 1974).

As part of the definition of "disability" under the Act, Congress included the following "grandfather" clause:

> [A]n individual shall also be considered to be disabled for purposes of this subchapter if he is permanently and totally disabled as defined under a State Plan approved under subchapter XIV or XVI of this chapter as in effect for October 1972 and received aid under such plan (on the basis of disability) for December 1973 (and for at least one month prior to July 1973), so long as he is continuously disabled as so defined. 42 U.S.C.A. § 1382c(a)(3)(E) (Supp. 1980).

The requirement that the individual be disabled for at least one month prior to July 1973 was introduced as a last minute amendment to the original provision. The purpose of this "rollback" amendment was to prevent states from transferring their welfare recipients onto the disability rolls in anticipation of the federal takeover. Those individuals who received disability aid under a state plan during December 1973 but who had not received aid under such plan for at least one month prior to July 1973—known as "rollbacks"—were subsequently classified, pursuant to agency regulations, as "presumptively disabled" and thus were eligible to receive SSI benefits until an initial determination of eligibility could be made. See 42 U.S.C.A.§1383(a)(4)(B) (Supp. 1980), 20 C.F.R. § 416.954. In contrast, the availability of federal disability benefits to those individuals who had received aid under a state plan for at least one month prior to July 1973—commonly known as "grandfatherees"—is controlled solely by the operation of the statutory grandfather clause.[1]

II. *FINNEGAN'S ACHE*

On November 16, 1972 appellant Finnegan's application for state disability was approved by the state of Washington disability review board. Finnegan received benefits from the state until January 1, 1974 at which time he was converted to and began receiving benefits from the federal SSI program. Based on the time period during which he had received disability benefits pursuant to the state plan, Finnegan qualified as a grandfatheree under the Act.

In December, 1975, Finnegan received notice that his benefits would cease on the basis that his medical condition had allegedly improved and his disability had ceased. Finnegan challenged these conclusions and contested the decision to terminate his benefits. At the agency hearing, the administrative law judge ("ALJ") concluded that Finnegan's medical condition had not improved, but nevertheless found that HEW was entitled, based on agency regulations, to make an "initial determination" of Finnegan's eligibility. Reviewing the evidence presented at the hearing, and based on an independent reading of the formerly employed state statute, Washington Administrative Code, Section 388-24-370,[2] the ALJ concluded that Finnegan was not "disabled," The district judge affirmed the finding that Finnegan's condition had not improved, but concluded that the Secretary had the authority to "initially determine" the eligibility of both grandfatherees and rollbacks. Finding that substantial evidence supported the "initial determination" of no disability in the case at bar, the district judge affirmed the termination of Finnegan's benefits.

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[1] A review of the statutory scheme governing the payment of benefits to rollbacks is necessary in order to fully understand the case law in this area. *See infra*, p. 7.

[2] Washington Administrative Code, Section 388-24-370 provides:

> "(1) In general, permanently and totally disabled means that the individual has some permanent physical or mental impairment, disease or loss that substantially precludes him from engaging in a useful occupation within his competence, such as holding a substantially gainful job or homemaking."

III. *TO HAVE OR HAVE NOT: TWO INTERPRETATIONS OF THE CLAUSE*

[1] On appeal, Finnegan argues that the grandfather clause of the Act operated to automatically qualify grandfatherees to receive SSI benefits. Having been qualified by congressional grandfathering to receive benefits—or, more correctly, having been exempted from the requirement that a potential recipient's eligibility be "initially determined" by the Secretary—Finnegan contends that it was improper for the Secretary to terminate his benefits based on an "initial determination" and in the absence of any express finding of either medical improvement or error in the earlier state determination of eligibility.[3]

In support of its right to "initially determine" a grandfatheree's eligibility for SSI benefits and, therefore, to terminate such benefits without a finding of medical improvement or error in the earlier state assessment of eligibility, HEW advances a significantly different interpretation of the grandfather clause. HEW argues that the clause was intended merely to guarantee the continued receipt of benefits by grandfatherees pending the Secretary's "initial determination" of continued disability. In contrast, individuals classified as "rollbacks" faced the danger of having had their benefits terminated (as of January 1, 1974), pursuant to the Act, pending the "initial determination" of their disability based on federal standards.[4] Thus, HEW argues, the grandfather clause should be read not to displace the agency regulations governing the proper means of determining eligibility, but merely to provide for continued payment until a proper determination could be made.

The main HEW regulation governing "initial determinations" provides:

> Initial Determinations
>
> The Administration shall, with respect to the application (or conversion) of ... any individual who is or claims to be an eligibile individual ..., make findings of fact setting forth pertinent conclusions and an initial determination with respect to eligibility for supplemental security income benefits and the amount of such benefits.... 20 C.F.R. § 416.1403(a).

HEW reasons that since Finnegan was being "converted" to the federal SSI program, and since the grandfather clause should not be read to displace regulation 416.1403(a), Finnegan was required to satisfy an initial determination of eligibility in order to prevent the termination of his benefits. Since substantial evidence supports the finding that, based on an "initial determination," Finnegan was not disabled, HEW concludes that the decision to terminate benefits should be affirmed.

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[3] We reject the Secretary's contention that Finnegan failed to raise this claim in the court below and thus has waived it. Although worded in a slightly different manner, the heart of Finnegan's argument before both the ALJ and the district judge was that he was exempt from the requirement of an "initial determination."

[4] As noted earlier, this potential hardship to the rollbacks was prevented by the decision of the Secretary to view all rollbacks as "presumptively disabled" and, therefore, as qualified to receive benefits, pursuant to regulation, pending the "initial determiantion" of their eligibility. See page 3, *supra*.

IV. *IN QUEST OF THE HOLY GRAIL: SEARCHING FOR THE MEANING OF THE STATUTE*

While success for the novelist often lies in suggestive ambiguity allowing the readers to share in the process of creation, perfection for a statute's crafter [Sic] lies in unquestionable clarity, forcing his audience to participate only in the process of implementation. When those charged with the responsibility of enforcing a statute find sufficient ambiguity by which to substitute creation for rote implementation, the judiciary must insure that the interpretation of the statute conforms to the probable intent of statute's collective authors. Not gifted with literary omniscience, the judiciary must rely on the words of the statue, legislative history, subsequent case law, common sense and consideration of relevant policy implications in order to properly shape its critique.

(a) *Plain Meaning*

[2] The best indicator of what statutory words mean is what they say.[5] In the present case, the grandfather clause provides that grandfatherees—like Finnegan—are to "be considered disabled for purposes of [the federal statute] if [they are] ...disabled as defined under a state plan ...so long as they are continuously disabled *as so defined.*" 42 U.S.C.A. § 1382c(a)(3)(E)(Supp. 1980) (emphasis added). The words "as so defined" refer back to the state definition of "disabled" and seem to be largely dispositive of the case. The grandfathered beneficiary is assured of receiving benefits, and correlatively, is legislatively exempt from ever having to meet the federal eligibility criteria, as long as he continues to satisfy the criteria formerly adopted and employed by the appropriate state in assessing "disability."

[3,4] It is relatively easy to locate the former state statute based on which a grandfatheree was ruled to be "disabled;"[6] however, even the wisdom of hindsight will often be insufficient to allow an ALJ to understand fully how a state disability statute had been routinely interpreted and applied by the relevant administrators. Hence, it is indeed difficult, if not impossible, for an ALJ to properly assess whether a recipient is "continuously disabled" under the "complete" state standard. An ALJ's inquiry must therefore focus on whether a clear and specific error had been committed during the

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[5] The plain meaning of words and not the perception of such words by interested parties like the HEW shall always be the "master":

> "When I use a word" Humpty Dumpty said, in a rather scornful tone, "it means just what I choose it to mean—no more, no less." "The question is," said Alice, "whether you can make words mean so many different things." "The question is" said Humpty Dumpty, "which is to be master—that all." L. Caroll, *The Annotated Alice*, 269 (1960).

[6] In fact, as noted above, the ALJ in the present case referred to the applicable Washington state statute in making his "initial determination." *See* page 3 *supra*.

previous state determination of eligibility[7] and on whether the recipient's medical condition has materially improved. Absent a finding of clear and specific error in the earlier determination a recipient must logically have been "disabled under a state plan;" absent a finding of subsequent material medical improvement a recipient must logically still be disabled "as so defined." The words of the statute could scarely be clearer in providing that it is the recipient's condition and not the identity of the enforcing agency which must change in order to terminate disability benefits. The Secretary may not terminate benefits absent a showing of previous clear and specific error or medical improvement which is sufficient to establish that an applicant is no longer "continuously disabled as so defined."[8]

B. *Case Law*

Although it is scarce and by no means (in itself) dispositive on the issue, the case law in the area lends support to Finnegans's interpretation of the grandfather clause. While no case directly considers the question of terminating SSI benefits to former state recipients who are covered by the grandfather clause, several cases focusing principally on the rights of "rollbacks", see note 1, *supra*, discuss the position of grandfatherees in an effort to distinguish the eligibility of the two groups. The dicta in each of these cases indicate that their judicial authors considered grandfatherees to be automatically eligibile for SSI benefits and exempt from HEW's "initial determinations."

The Courts of Appeals have consistently referred to the position of grandfatherees as "conclusively presumed" to be qualified for federal SSI benefits. In *Johnson v. Mathews*, 539 F.2d 1111 (8th Cir. 1976), the Eighth Circuit noted in dicta that while grandfatherees were "conclusively presumed" to meet federal standards, rollbacks were not "automatically qualified." Id. at 1115. Similarly, in *Ryan v. Shea*, 525 F.2d 268 (110th Cir. 1975), the Tenth Circuit explained that:

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[7] For example, proof that the previous state determination had been materially influenced by an incorrect medical report could serve as sufficient grounds for finding that a former recipient is no longer "continuously disabled" under the state standard, even though the recipient's medical condition has not improved. On the other hand, the mere fact that an ALJ's independent assessment of a grandfatheree's eligibility under the former state statute differs from the state's former assessment of eligibility is not sufficient to find that clear error had been committed during the earlier determination. There has been no claim in the present case that a clear and specific mistake—such as reliance on a false medical report—was committed during the state determination of Finnegan's eligibility. Therefore, we assume that no clear error had been committed in this case.

[8] Although there is a dearth of legislative history concerning the proper interpretation of the grandfather clause, the existing history supports the conclusion that Congress did not intend to allow the Secretary to make "initial determinations" of the eligibility of grandfatherees. For example, the report of the House Ways and Means Committee, H.R.Rep. No. 92-231, 92nd Cong., 2nd Sess. (1972) reprinted in U.S. Code Cong. & Ad. News 4989, includes a statement which indicates that that committee thought that grandfatherees would automatically qualify for federal SSI benefits: "In order to facilitate an orderly transitional process, those blind and disabled people who are on the benefit rolls in June 1972 under existing State programs would be considered blind or disabled for purposes of this program." *Id.* at 5134.

> As a part of the definition of eligibility, Congress included a "grandfather" clause whereby persons receiving disability benefits from a state program as of December 1973 would be conclusively presumed to meet federal standards. We would note parenthetically that the federal program was in one sense, at least, a continuation of the old federal-state program. Id. at 270.

See also, Tatum v. Matthews, 541 F.2d 161, 163 (6th Cir. 1976).[9]

Finnegan's interpretation of the grandfather clause is even more strongly supported by the district court opinions in the area. For example, in *Buckles v. Weinberger,* 398 F.Supp. 931 (E.D.Pa.1975), the court informatively noted:

> Thus, this [grandfather] provision provided, in essence, that each and every recipient under a state plan in December of that year would automatically begin to receive benefits under SSI for the following month. It is clear from this "grandfather" clause that *SSI was intended by Congress as a wholesale replacement for, and continuation of, the former state-federal programs,* in that the identity of recipients under the two plans of assistance would be absolute. It was only with respect to *future* applicants for SSI that the uniform federal criteria were to apply. Id. at 939 (emphasis in original).

Similarly, in *Brown v. Weinberger,* 382 F.Supp. 1092 (D.Md.1974), aff. 529 F.2d 514 (4th Cir. 1975), the court noted that grandfatherees were "automatically" and unconditionally" qualified for conversion to SSI. Id at 1094 (dicta). Finally, the Secretary's argument was again expressly rejected in *Savrino v. Weinberger,* 396 F.Supp. 992 (D.R.I.1975) where the court, in refuting a different argument advanced on behalf of the Secretary, noted:

> Basic to the defendant's argument is the assumption that Congress intended to restrict SSI eligibility to only those who specifically qualified for the SSI program under SSI definitions of eligibility. This assumption, however, empirically denied by the fact that all persons who received [state] benefits prior to July of 1973 were automatically "grandfathered" into the SSI program with no requirements that their eligibility be reviewed under the "new" SSI definitions. Id. at 1001 (dicta).

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[9] The only 9th Circuit case on the subject, *De Lao v. Califano,* 560 F.2d 1384 (9th Cir. 1977) while not shedding a great deal of light on the issue at bar, does indicate an assumption that only rollbacks would be required to meet federal eligibility standards:

Under the new SSI program, the federal government assumed most of the burden of providing benefits to those needy persons who were disabled as defined by the Act. As part of the definition of disability, Congress included a "grandfather" clause whereby persons receiving disability benefits as of December, 1973, under a state plan approved under former Title XIV or XVI as in effect for October, 1972, were considered disabled for purposes of the new SSI program. 86 Stat 1471-72, 42 U.S.C. § 1382c(a)(3)(A) (Supp 11, 1972).

... As a result, all persons who became qualified under a state plan after July 1, 1973, had to meet the new federal standards of disability to be eligible under the SSI program. Id. at 1386.

D. *Policy Analysis and Common Sense*

In addition to violating the plain meaning of the statute and the clear language—albeit in dicta—of every case discussing this issue, the Secretary's argument seems to cut against both policy and common sense. In 1972, Congress revamped the social security system to create a centrally and federally administered disability program. The new program established uniform standards of eligibility to be enforced by a single decision-making body. Within this framework, Congress specifically exempted those individuals who had previously qualified for benefits under state law from the burden of satisfying the new uniform federal standards. This exemption was accomplished through the inclusion within the new Act of a provision commonly referred to as a "grandfather" clause.

[5] The sole function of a grandfather clause is to prevent the harsh and often unfair operaion of a statutory change. In the case at bar, the statutory revision threatened to deprive individuals of the continued right to receive disability benefits. The unfairness which could have resulted from the statutory change—the undesired potential side effect of the new disability program—would have been the discontinuance of benefits to former recipients prompted solely by a change in the rules of the game and undertaken in the absence of any improvement in their disabling condition. This harsh side effect was averted through the inclusion of the grandfather clause. Yet, by reading the clause not as an exemption from prejudice, but as a temporary delay of the onset of such prejudice, the Secretary seeks to preserve the same harsh side effect which the grandfather clause was intended to eliminate. The Secretary's interpretation[9a] of the provision would completely undermine the very purpose for which the grandfather clause was adopted.[10]

V. *FROM HERE TO ETERNITY: CONCLUSION*

The tools of statutory interpretation clearly indicate that the grandfather clause was designed to qualify automatically those included within its coverage for SSI benefits, and correlatively, to exempt grandfatherees from the requirement of undergoing "initial determinations" of eligibility by HEW. Therefore, benefits to a grandfatheree must not be terminated absent proof of a material improvement in his medical condition or of the commission of a clear and specific error during the prior state determination. Since there has clearly been no material improvement in Finnegan's medical condition or clear and specific error in the prior state proceedings awarding benefits to Finnegan, it was improper for the district court to allow a termination of Finnegan's benefits. The decision of the lower court is therefore

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[9a] We are mindful of the maxim that a court should give deference to the interpretation of a statute by the agency charged with its administration. *Brubaker v. Morton,* 500 F.2d 200 (9th Cir. 1974). It is well established, however, that "Reviewing courts are not obliged to stand aside and rubber-stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute." *National Labor Relations Board v. Brown Food Store,* 380 U.S. 278, at 291, 85 S. Ct. 980, at 988. 13 L.Ed 2d 839 (1965); *Usery v. First National Bank of Arizona,* 586 F. 2d 107, 111 (9th Cir.).

[10] As an extreme example, the Secretary could have set out on January 2, 1974 to make the first "initial determination" of the eligibility of a grandfatheree. A former state recipient could then have been disqualified from receiving benefits (without any change in his condition) on the first day of the program. The grandfather clause would have thus been rendered totally meaningless.

REVERSED.

SECTION 1614(f)(2)(42 U.S.C. 1382c(f)(2)) SUPPLEMENTAL SECURITY INCOME—CHILD TEMPORARILY ABSENT FROM PARENTS' HOME DUE TO SCHOOL ATTENDANCE—DEEMING OF INCOME

20 CFR 416.1056, 416.1165, and 416.1167(a) **SSR 82-11**

When the claimant's father applied for supplemental security income (SSI) benefits and optional State supplementation on his son's behalf in November 1979, the claimant was 17 years old, unmarried, and attending a school for the emotionally disturbed. The Social Security Administration (SSA) determined that the claimant was a "child" who was living in the same household as his parents. Consequently, the income of his father was counted, as provided by statute, in determining his eligibility for benefits under the SSI program. With the inclusion of his father's income, the claimant was ineligible for both SSI benefits and optional State supplementation because he had excess countable income. When SSA denied the application, the claimant's father appealed. The record shows that, even though the claimant resides at the school, he is still subject to the control of his parents and that he comes home for holidays, school vacations, and occasional weekends. *Held,* under 20 CFR 416.1167(a)(2), the claimant, who meets the definition of a "child" in 20 CFR 416.1056, is living in the same household with his parents because his absences due to attendance at school are temporary. *Further held,* the claimant's income is deemed to include, as provided in section 1614(f)(2) of the Social Security Act (the Act), the income of his father; therefore, the claimant is ineligible for benefits under the SSI program because he has excess countable income.

The general issue to be determined is whether the claimant is eligible for SSI benefits under section 1611 of the Act. The specific issue is whether the claimant's income exceeded that specified by section 1611 of the Act. This depends on the claimant's income (including income deemed to him) and his living arrangements.

The claimant's application for SSI benefits, filed on November 26, 1979, was denied on the grounds that his income (including the income deemed to him from his father's earnings), less applicable exclusions, was in excess of the amount allowed for the receipt of SSI benefits and optional State supplementation.

At the hearing, the 17 year old claimant testified that he has attended a special school for the past three years. He is in ungraded classes, taking courses in mathematics, reading, social studies, and English. He resides at the school, but comes home to the private house of his parents for all holidays. He also comes home for the midwinter recess in February and for occasional weekends. At his home, he has his own room where a bed, dresser, clothes, radio, and television are maintained for him by his parents.

The claimant's father testified that the claimant was attending the special school because of an emotional disturbance. The school district and the county in which the claimant's parents reside pay for the cost of the claimant's education, food, and shelter while he is at the school. The claimant's father pays for his medical needs, transportation, and entertainment. The father stated that the claimant's testimony concerning the time he spends at the school and the time he spends in the home of his parents was accurate, adding that the claimant comes home to his parents' house about one weekend a month. The father testified further that he earns $25,000 to $27,000 a year and that he and his wife have no children other than the claimant.

The documentary evidence establishes that the school the claimant attends is certifed by the State Board of Social Welfare as a child care facility providing care and therapeutic treatment for students with mild to severe emotional disabilities. The school district placing the child pays the tuition for students attending the school and is reimbursed by the State Education Department. Maintenance costs for the students are paid by the county which places the student. The parents of the children at the school do not relinquish parental control or responsibility to the school.

Section 1611(a) of the Act, in part, provides certain income limitations that a person must meet to be eligible for SSI benefits.

Section 1612(a) of the Act, provides that "income" means both earned and unearned income. "Earned income" means wages and net earnings from self-employment. "Unearned income" means all other income.

Section 1612(b)(2)(A) of the Act provides that in determining the income of an individual there shall be excluded "the first $240 per year (or proportionately smaller amounts for shorter periods) of income (whether earned or unearned) other than income which is paid on the basis of the need of the eligible individual."

Section 1614(c) of the Act defines "child" to mean an individual who is neither married nor the head of a household and who is (a) under the age of 18 or, (b) under the age of 22 and a student regularly attending school, college, or university or a course of vocational or technical training designed to prepare him for gainful employment.

Section 1614(f)(2) of the Act provides that "for purposes of determining eligibility for and the amount of benefits for any individual who is a child under age 18, such individual's income and resources shall be deemed to include any income and resources of a parent of such individual (or the spouse of such a parent) who is living in the same household as such individual, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances."

Section 416.1165 of Regulations No. 16 explains how income from an ineligible parent is deemed to a child as unearned income.

> Section 416.1167(a) of Regulation No. 16, in part, provides that—"If you and your ineligible . . . parent stop living in the same household, we stop applying deeming rules with the first full month that one of you is absent, unless the absense is temporary . . . . (2) If you are an eligible child who is away at school but comes home on some weekends or lengthy holidays and if you are subject to the control of your parents, we consider you

> temporarily absent from your parent's household . . . ."
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> Section 416.2025(b)(4) provides that—
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> "No State supplementary payment will be made where countable income is equal to or exceeds the sum of the Federal benefit rate and the State supplementary payment rate."

The testimony given at the hearing and the documentary evidence demonstrates that, for purposes of deeming income under section 1614(f)(2) of the Act, the claimant, while attending school, is considered only temporarily absent from the household of his parents. The testimony showed that the claimant comes home for all holidays, one weekend a month, and between semester recesses. There is no evidence, such as a signed document, that the claimant's parents have relinquished parental control over the claimant. The school is considered only in loco parentis of the claimant's parents, as any school is to a student while the school is in session. That is, the school stands in the place and the stead of the claimant's parents in exercising authority over the claimant only because of the claimant's physical absence from his parents while attending school. Complete living facilities are provided for the claimant in the household of his parents on an annual basis. The payment of the claimant's tuition and maintenance charges at the school by the school district and county in which the claimant's parents reside corroborates that the claimant lives in his parent's household. Under these circumstances, the claimant is considered only temporarily absent from the household of his parents, that is, under §416.1167(a)(2) of Regulations No. 16, he is considered to be residing in the household of his parents.

Because the 17 year old claimant is a "child," as defined in section 1614(c) of the Act, and resides in the household of his parents, his income is deemed to include the income of his father, as provided in section 1614(f)(2) of the Act. Under §416.1165 of Regulations No. 16, the claimant's father's income, less the applicable allocations explained in that section, is deemed to the claimant as unearned income. With the inclusion of the deemed income, the claimant is ineligible for both SSI benefits and optional State supplementation because he has excess countable income.

Part 1B
Rulings Based on Program Policy Statements

SSR-82-12

TITLE XVI: ALERTING TITLE II APPLICANTS TO POSSIBLE TITLE XVI ELIGIBILITY
(SSR 80-16 (Published as PPS-48) (Rescinded)

SSR 80-16 (C.E. 1980, p. 96), which provided policy to ensure that title II (Social Security) applicants potentially entitled to supplemental security income (SSI, title XVI) are made aware of their rights to SSI, is rescinded without replacement. Procedures fully protecting the rights of those applicants are provided in current operating instructions.

(Previously Published as PPS-62)

SSR 82-13

PROGRAM FOR ONGOING REVIEW OF HEARING DECISIONS PURSUANT TO SECTION 304(g) OF PUBLIC LAW (P.L.) 96-265
APPEALS COUNCIL'S REVIEW AUTHORITY

PURPOSE: To announce SSA's institution of a program for ongoing review of administrative law judge decisions in the Office of Hearings and Appeals and to state the policy on Appeals Council review of hearing decisions upon the Appeals Council's own motion under this program.

CITATIONS (AUTHORITY): Sections 205 and 1631(c) and (d), of the Social Security Act, as amended; section 304(g) of Public Law 96-265; Social Security Administration Regulations, title 20, Code of Federal Regulations, sections 404.969, 416.1469, and 422.205; Statement of Organization, Functions and Delegations of Authority (45 FR 79168, November 28, 1980); and Decision of the Commissioner of Social Security dated July 20, 1981.

PERTINENT HISTORY: By delegation of authority from the Secretary of Health and Human Services, the Appeals Council of the Office of Hearings and Appeals, Social Security Administration, reviews decisions and dismissal actions of administrative law judges involving retirement, survivors, disability, health insurance, and supplemental security income on motion of appellants or on its own motion.

Section 304(g) of Public Law 96-265, enacted June 9, 1980, states that: "The Secretary . . . shall implement a program of reviewing, on his own motion, decisions rendered by administrative law judges as a result of hearings under section 221(d) of the Social Security Act . . . ."

As a result of this provision, SSA is instituting a new review process, as described in this Program Policy Statement. In implementing this process the Appeals Council will, where appropriate, exercise its preexisting, own motion review authority.

The statutory provision is the result of Congressional concern about what is considered a high overall percentage of claims for disability benefits allowed at the hearing level and the wide variance in allowance rates among individual administrative law judges. It also reflects Congressional intent that there should be a review program that incorporates the same adjudicative principles that bind the administrative law judges and provides for uniformity of decision making at all adjudicatory levels.

Although the Appeals Council of the Office of Hearings and Appeals (OHA) receives and acts upon requests for review submitted by claimants dissatisfied with hearing decisions and dismissals, in the past several years the Council has not conducted an ongoing, pre-effectuation review of favorable administrative law judge decisions for the purpose of identifying the need for, and, where necessary, taking corrective action. Consequently, in accordance with the statutory mandate, OHA will conduct a comprehensive, ongoing program under which a prescribed percentage of administrative law judge decisions involving the issue of disability, particularly those allowing previously denied claims for disability benefits, will be evaluated prior to their effectuation, even though there is no request for review. When appropriate, the decision will be referred for possible review by the Appeals Council.

"Review" has a specific meaning as it relates to the Appeals Council. To "review on its own motion," when "the Appeals Council reviews," or similar usage means that the Appeals Councils stays the effect of the hearing decision with the intent to issue a new decision or order an administrative law judge to issue a new decision. It is important to note that P.L. 96-265 requires only the establishment of a program for reviewing cases upon the Secretary's own motion; it does not require the Appeals Council to review any specific case unless it decides there is reason to do so. Once the Appeals Council decides to review a hearing decision on its own motion, it may affirm, reverse or modify the decision or remand the case to an administrative law judge for further proceedings.

The policies for own motion review under section 304(g), as well as the delegation of authority to the Appeals Council, are stated herein for public understanding in view of the institution of an ongoing program of evaluation of administrative law judge (ALJ) actions, particularly those which result in decisions favorable to the claimants.

POLICY STATEMENT: The Appeals Council is charged with insuring that the final actions of the agency are proper and in accordance with the law, regulations and binding agency policies. As herein pertinent, the regulations of the Social Security Administration with respect to Appeals Council review provide as follows:

Sections 404.969 and 416.1469

> "Appeals Council initiates review. Anytime within 60 days after the date of a hearing decision or dismissal, the Appeals Council itself may decide to review the action that was taken . . . ."

The regulations provide the Appeals Council the discretionary authority to review any decision or dismissal action for any reason. This is not a newly acquired authority but has existed for many years.

The ongoing review in accordance with P.L. 96-265 will be implemented primarily on the basis of the categories set forth below. Upon full consideration of the entire record, the applicable law, regulations and binding policies, the Appeals Council will exercise its own motion authority if any one of the following is present. (Binding policies which are not published in the Federal Register are generally available as Social Security Rulings, but also may be available in some other form when they have been identified pursuant to 5 U.S.C. 552(a)(2) as statements of policy and interpretation which have been adopted as binding by the Commissioner of Social Security.)

The Appeals Council will review a hearing decision if there appears to be an abuse of discretion by the administrative law judge. Such abuse will be considered present where an action taken by the administrative law judge is erroneous and without any rational basis, such as where there has been an improper exercise, or a failure to exercise, administrative authority. Although this concept cannot be defined comprehensively, examples of abuses of discretion include: failure to have the claimant submit evidence necessary to support his/her claim; failure to conduct a full and fair hearing; and failure to allow postponement of a scheduled hearing despite physician documentation of the claimant's unavailability for health reasons. An abuse of discretion may also occur where there is a failure to follow procedures required by law.

The Appeals Council will review a hearing decision for error of law. Error of law exists where there has been misinterpretation or misapplication of, or failure to consider, pertinent provisions of law, regulations, and binding agency policies. Misinterpretation or misapplication occurs where the decision is contrary to statutory or regulatory provisions or agency policies or where the decision is based on an erroneous legal standard.

The Appeals Council will also review a hearing decision where it is not supported by substantial evidence. Substantial evidence may be defined as that amount of evidence which, while it may be less than a preponderance, nevertheless is sufficient to convince a reasonable mind of the validity of a position taken on an issue. Under the substantial evidence rule, the Appeals Council evaluates the hearing decision by looking to the record as a whole in order to determine if sufficient evidence exists to support the administrative law judge's action, and stated findings and conclusions. This requires that the decision be based on sufficient quantity and quality of evidence so that a reasonable mind might come to the same conclusion.

In addition, the Appeals Council will review a hearing decision where there is a broad policy or procedural issue that may affect the general public interest. Review for this reason will generally be limited to circumstances in which a decision raises or addresses a question which has potentially far-reaching applicability for a significant number of claims.

The Appeals Council will not ordinarily review a hearing decision where the end result would remain unchanged unless there is a compelling need to do so.

Nothing in this Program Policy Statement alters or affects the Appeals Council's authority to reopen a decision under the rules set forth in regulations sections 404.988 and 416.1488. Under these regulations, the Appeals Council may reopen for any reason any decision within 12 months of the date of the notice of the initial determination. After 12 months, the Appeals Council may reopen a decision for such reasons as specified in the regulations.

The procedures and instructions for staff which provide support to the Appeals Council in performing its review functions are contained in staff manuals.

EFFECTIVE DATE: The ongoing program of comprehensive evaluation of administrative law judge actions within OHA commenced effective October 1, 1981.

CROSS-REFERENCES: Claims Manual sections 7166.4 and 13691.5.

(To be Published as PPS-63) **SSR 82-14**

TITLE II AND TITLE XVI: REQUIREMENTS FOR CONSULTATIVE EXAMINATIONS AND TESTS PURCHASED IN CLAIMS BASED ON DISABILITY

PURPOSE: To state the policy on consultative examinations purchased at Federal Government expense in disability claims filed under the Social Security (title II) and Supplemental Security Income (title XVI) Programs.

CITATIONS (AUTHORITY): Sections 223(d)(5) and 1633 of the Social Security Act; regulations Nos. 4 and 16, sections 404.1513, 404.1517, 416.913 and 416.917.

PERTINENT HISTORY: Section 223(d)(5) of the Social Security Act provides, in pertinent part, that an individual shall not be considered to be under a disability unless he or she furnishes such medical and other evidence as the Secretary may require. Under implementing regulations (20 CFR sections 404.1512-404.1518 and 416.912-416.918), determinations as to disability are based on evidence supplied by the claimant's own medical sources and, where needed, on independent physical or mental examinations or tests purchased at Federal Government expense. Such examinations, referred to as "consultative examinations (CE's)," may be needed in order to: (1) to obtain more detailed medical findings about the claimant's impairments; (2) obtain technical or specialized medical information; or (3) resolve conflicts or differences in medical findings in the evidence already in file.

The regulations, as well as disability operating instructions, clearly intend that evidence obtained as a result of purchased examinations or tests will permit sound adjudication to be made when such evidence is considered along with all other medical and nonmedical evidence submitted in connection with a disability claim. To constitute evidence acceptable for adjudicative purposes, the CE must be performed by a competent physician,[1] and the report must be complete and personally reviewed and signed by the individual who actually performs the examination and/or tests.

POLICY STATEMENT: Consultative examinations and tests purchased in connection with the adjudication of title II and title XVI disability claims must be performed by qualified sources. Those sources and the reports they furnish must reflect the following essential characteristics:

1. **Physician Qualifications**—The physician doing the examination or test must be competent to do so. While the Social Security Administration (SSA) does not require that the physician be a specialist in the medical field in which the examination or test is requested, the physician's qualifications must indicate that he or she is licensed and, in the judgment of the Disability Determination Services (DDS), has the training and experience to perform the type of examination or test requested. The physician's professional conduct and reputation must be such as to avoid an unfavorable reflection upon the government and erosion of public confidence in the administration of the program.

2. **Physician Independence**—All implications of possible conflicts of interest must be avoided. For example, the physician doing the examination or test must not be a full-time or part-time employee of a State DDS or any component of SSA unless there is no other qualified medical resource available. In such instances, the physician cannot participate in the disability decisionmaking or review process on that claim. Also, the physician must not have any familial, financial, or other relationship to the claimant, e.g., as an actual or potential representative payee.

3. **Report Content**—The reported results of the history, examination, pertinent requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a

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[1] It is recognized that CE's will occasionally be performed by specialists other than physicians such as psychologists, audiologists, etc. In such situations, the guidelines spelled out in this PPS are applicable to the extent possible.

complete and competent examination. SSA recognizes that the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. Thus, the extent and detail of information expected in a report of a general internal medicine examination will differ from that expected when a neurological, orthopedic, psychiatric, psychological, ophthalmological, otological or other examination is requested to address a specific issue. Moreover, the reporting of information will differ when the requested examination evidence relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. When a complete examination is involved, the report should include:

a. The major or chief complaint(s) of the claimant.
b. Within the area of specialty of the examination, a detailed description of the history of the major complaint(s).
c. A description, and disposition, of pertinent "positive," as well as "negative," detailed findings based on the history, examination and laboratory tests related to the major complaint(s) and any other abnormalities reported or found during examination or laboratory testing.
d. The results of requested laboratory tests performed according to the requirements stated in the Listing of Impairments (see Regulations Nos. 4 and 16; appendix 1); and the results of other tests (e.g., X-rays of the most involved arthritic joint) that are found necesary as a result of the physician's examination. (Such tests require DDS physician authorization.)
e. Diagnosis and prognosis.
f. A medical assessment (except in statutory blindness claims and disability claims for widows and widowers) which shows the claimant's ability to do work-related activities or to function in a work setting.

In addition to the above, the consultative physician must consider, and provide some explanation or comment on, the major complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory tests. The history, examination, evaluation of laboratory test results, and the conclusions must represent the information provided by the physician who signs the report.

4. **Physician Signature—**The physician actually performing the consultative examination or testing must personally review and sign the report; the signature of any other physician or person is not acceptable. This attests to the fact that the physician doing the examination or testing is solely

responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory tests results.[2]

EFFECTIVE DATE: This policy is effective upon receipt.

CROSS REFERENCES: Program Operations Manual System, part 4, sections DI 2026.B., 2027-2028.

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[2] In some instances, a medical technician or other paraprofessional will contribute to the information (e.g., x-rays or laboratory findings) contained in a medical report. In such cases, the physician signing the report must verify the reported findings and conclusions.

Part II
Changes in Law and Regulations

REGULATIONS

82-II-11

The following amendments and additions under titles II and XVI of the Social Security Act and title IV of the Federal Coal Mine Health and Safety Act of 1969 have been published in the Federal Register:

A. REGULATIONS NO. 4—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE (20 CFR PART 404)

1. Subpart G—Amendments to this subpart were published in the Federal Register (46 FR 47444) on September 28, 1981.

   These regulations reduce from 12 months to 6 months the maximum retroactivity of applications for Social Security insurance benefits that are not based on the worker's disability or the disability of a widow or widower.

2. Subpart M—Amendments to this subpart were published in the Federal Register (46 FR 43963) on September 2, 1981.

   These regulations govern the frequency with which States and interstate instrumentalities must deposit Social Security contributions on wages and salaries paid to covered employees.

3. Subpart P—Amendments to this subpart were published in the Federal Register (46 FR 45756) on September 15, 1981.

   These regulations provide that any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician who is not employed by the Federal government, and who supplies medical evidence that the Social Security Administration asks for and needs for making determinations of disability shall be entitled to payment for the reasonable cost of providing the evidence.

4. Subpart Q—Amendments to this subpart were published in the Federal Register (46 FR 29190) on May 29, 1981.

   These regulations prescribe standards for accuracy of performance and processing time that State agencies must meet in making disability determinations, and provide the administrative requirements and procedures SSA and the State agencies will follow in carrying out the disability determination function. Provisions are included specifying how SSA or a State may terminate the State agency's performance of this function.

B. REGULATIONS NO. 16—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED (20 CFR PART 416).

   1. Subpart J—Amendments to this subpart were published in the Federal Register (46 FR 29190) on May 29, 1981.

      Refer to item A-4 above for description of changes.

   2. Subpart K—Amendments to this subpart were published in the Federal Register (46 FR 57275) on November 23, 1981.

      Under these regulations, payments provided under title XX or other governmental programs to pay an ineligible spouse or ineligible parent for in-home supportive services (chore, attendant, homemaker) for an eligible individual are no longer deemed to be the income of the eligible individual.

   3. Subpart S—Amendments to this subpart were published in the Federal Register (46 FR 47445) on September 28, 1981.

      These regulations reorganize and restate the Social Security Administration's (SSA's) rules on interim assistance provisions under the Supplemental Security Income (SSI) program. They permit SSA to enter into an agreement with a State to repay the State for interim assistance it gives an individual while his or her application for SSI is pending.

C. REGULATIONS NO. 10—FEDERAL COAL MINE HEALTH AND SAFETY ACT OF 1969, TITLE IV—BLACK LUNG BENEFITS.

   1. Subpart E—Amendments to this subpart were published in the Federal Register (46 FR 39588) on August 4, 1981.

      These regulations provide that when an overpayment of black lung benefits is made to a black lung beneficiary, the Social Security Administration may recover the overpayment from subsequent black lung benefits payable to the decedent's survivors.

Part III
Items of General Interest

New and Revised Pamphlets

SSR 82-III-I

The following new and revised booklets and pamphlets explaining various aspects of the retirement, survivors, disability, and supplemental security income provisions of the Social Security Act, as amended, and of the black lung provisions, have become available for distribution. Single copies of these and other leaflets and booklets are available without cost at any Social Security office. Information on quantity purchases may be obtained from such office or from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

1. Your Right to Appeal Decisions On Hospital Insurance Claims. SSA Publication No. 05-10085, July 1981.

   This leaflet explains how to appeal a decision made on your hospital insurance claim.
2. Your Right to Question The Decision Made On Your SSI Claim. SSA Publication No. 05-11008, July 1981.

   This leaflet explains how to appeal a decision made on your SSI claim.
3. Estimating Your Social Security Retirement Check—For Workers Who Reached 62 Before 1979. SSA Publication No. 05-10047, August 1981.

   If you reached 62 before 1979, this leaflet provides a method that will enable you to estimate your retirement benefit. If you have an eligible spouse or child, or both, the leaflet will also enable you to estimate their benefit.
4. Applying For A Social Security Number. SSA Publication No. 05-10064, August 1981.

   This leaflet describes the evidence you must furnish when you apply for a Social Security number.
5. Estimating Your Social Security Retirement Check—For Workers Who Reach 62 In 1979-83. SSA Publication No. 05-10088, August 1981.

   If you reach 62 in 1979-83, this leaflet provides a method that will enable you to estimate your retirement benefit. If you have an eligible spouse or child, or both, the leaflet will also enable you to estimate their benefit.

6. Your Social Security. SSA Publication No. 05-10035, September 1981.

   A revision of the popular booklet which gives a brief overview of the Social Security program.

7. Thinking About Retiring? SSA Publication No. 05-10055, September 1981.

   A revision of the leaflet that answers many of the questions received about retirement and Social Security. It assists you in making your retirement planning a little easier.

8. A Message From Social Security—About the Special Medical Examination Needed for Your Disability Claim. SSA Publication No. 05-10087, September 1981.

   The leaflet provides information about the special medical examination that is arranged if additional medical evidence is needed to determine whether you are disabled under the Social Security law.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1982-361-184/105

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Rulings

Social Security Rulings

On Federal Old-Age,
Survivors, Disability,
Supplemental Security Income,
and Black Lung Benefits

APRIL 1982
SSR 82-15a to SSR 82-31

Department of Health
and Human Services
Social Security Administration
Office of Operational Policy and Procedure
SSA Pub No 65-002
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Preface

Social Security Rulings (the SSR) is published under the authority of the Commissioner of Social Security and makes available to the public a series of precedential decisions relating to Federal old-age, survivors, disability, supplemental security income, and black lung benefits programs. All reference to individual or specific businesses involved have been avoided so as not to disclose confidential information, unless already a matter of public record, as in a Federal court decision.

The SSR is based on case decisions, policy statements, decisions of the administrative law judges and the Appeals Council, opinions of the Office of the General Counsel, Commissioner's decisions, Federal court decisions, and other interpretations of the law and regulations. Once published, a ruling is binding on all components of the Social Security Administration in accordance with section 422.408 of Social Security Regulations No. 22 (20 CFR Part 422). Rulings do not have the force and effect of the law or regulations but are to be relied upon as precedents in determining other cases where the facts are basically the same. A ruling may be superseded, modified or revoked by later legislation, regulations, court decisions, or rulings.

Citations of a Social Security Ruling may be made by reference to the ruling number and the issue in which it appears. For example, ruling number one for 1980 would be cited as SSR 80-1 (Jan. 1980), or SSR 80-1 (C.E. 1980) if the annual Cumulative Edition has been published. Rulings based on court decisions are identified by a suffix "c" (such as SSR 80-1c), and rulings based on a decision of the Appeals Council of the Office of Hearings and Appeals are identified by the suffix "a" (such as SSR 80-1a).

All references to sections of law relate to sections of the Social Security Act, as amended, unless otherwise specified. All references to regulations, unless otherwise specified, are to Social Security Regulations Nos. 1, 4, 10, 16 and 22. These appear in title 20 of the Code of Federal Regulations as Parts 401, 404, 410, 416 and 422. The Code, revised as of April 1981, is available through the U.S. Government Printing Office at a subscription price of $525 per year (single copies cost $8). New and amended regulations are first printed in the *Federal Register;* individual copies may be purchased for $1.50.

The SSR is published quarterly—subscription price is $7.50 a year ($1.90 additional for foreign mailing); individual copies cost $2.25. An annual Cumulative Edition (formerly entitled the "Cumulative Bulletin") is published at the close of each calendar year reproducing all rulings published throughout the year which have not been superseded. The cumulatives for the two most recent years are available for sale from the U.S. Government Printing Office. Those currently available are the 1979 edition ($4.00) and the 1980 edition ($5.50). All other cumulative editions from 1960 on are available to the public free of charge upon request to the Social Security Administration, Office of Regulations, 6401 Security Blvd., Baltimore, Maryland 21235.

Other related publications available for sale through the U.S. Government Printing Office are:

1. *Compilation of the Social Security Laws*—a copy of the Social Security Act, as amended, is available in a paper cover edition entitled "The Social Security Act and Related Laws." It includes parts of the Internal Revenue Code and other laws pertinent to the Social Security Act. Inquiries made to the Superintendent of Documents, U.S. Government Printing Office, will supply the user the date of the current edition available and its cost.
2. *The Social Security Handbook*—the seventh edition, scheduled for publication in the Summer of 1982, reflects the provisions of the Social Security Act as amended through December 31, 1981. The Handbook is intended for the use of people who want a detailed explanation of the various programs administered by the Social Security Administration, how they operate, who is entitled to benefits, and how benefits may be obtained. Inquiries made to the Superintendent of Documents, U.S. Government Printing Office will supply the user with the cost of the Handbook.

These publications, including materials now being prepared or planned, when published, may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. A check or money order covering the cost of the publication should accompany the order.

Part IA
Rulings and Decisions

SECTION 202(b)(4) (42 U.S.C. 402(b)(4)) WIFE'S INSURANCE BENEFITS—GOVERNMENT PENSION OFFSET

20 CFR 404.408a **SSR 82-15a**

The claimant applied for Wife's Insurance Benefits as a divorced spouse in November 1979. Under section 202(b) (4) of the Social Security Act (the Act), the Social Security Administration (SSA) determined that such a benefit was subject to offset by the amount of her monthly State government pension. Section 334(g) of Public Law 95-216 provides an exception to offset for certain spouses who are or will be receiving a public pension within 5 years after the date of enactment. *Held*, the claimant does not qualify for the exception because she does not meet the 20-year marriage requirement in section 216(d) (1) of the Act as it was in effect and being administered in January 1977.

The issue before the Appeals Council is whether the Wife's Insurance Benefits payable to the claimant as a divorced wife are subject to reduction because of her receipt of a State government pension.

The claimant, who was born on September 4, 1909, filed an application for Wife's Insurance Benefits as the divorced wife of the wage earner on November 2, 1979. She was married to the wage earner on June 18, 1931 and was divorced from him on January 10, 1950. Because the claimant was married to the wage earner for less than 20 years, she did not meet the duration of marriage requirement under section 216(d) (1) of the Act until that section was amended by section 337(a) of Public Law 95-216 to require only a 10-year duration of marriage to meet the definition of a "divorced wife." The claimant was therefore found entitled beginning January 1979, the first month in which the amendment became effective.

The claimant receives a monthly State government pension of $127.53. On the last day of her employment for the State, her services did not constitute "employment" as defined in section 210 of the Act. This means that her services for the State were not covered for Social Security purposes.

It was determined initially and upon reconsideration that the claimant's State pension caused a dollar for dollar reduction in the amount of the Wife's Insurance Benefit payable to her as a divorced wife. The administrative law judge found, however, that the claimant's benefits were not subject to government pension offset because she was receiving her State pension in 1978.

Section 202(b) (1) of the Act provides, as pertinent herein, that a divorced wife, as defined in section 216(d) (1), of an individual entitled to Old-Age Insurance Benefits is entitled to Wife's Insurance Benefits if certain requirements are met.

Section 202(b) (4) of the Act, added by section 334(a) (2) of Pubic Law 95-216, provides that "the amount of a wife's insurance benefit for each month...shall be reduced...by an amount equal to the amount of any monthly periodic benefit payable to such wife (or divorced wife) for such month which is based upon her earnings while in the service of the Federal government or any State (or political subdivision thereof)...if, on the last day she was employed by such entity, such service did not constitute 'employment' as defined in section 210."

Section 216(d)(1) of the Act, as in effect prior to January 1979, provided that "the term 'divorced wife' means a woman divorced from an individual, but only if she had been married to such individual for a period of 20 years immediately before the date the divorce became effective."

Section 337(a) of Public Law 95-216 amended section 216(d)(1) by reducing the duration of marriage requirement from 20 years to 10 years effective with respect to benefit payments beginning January 1979.

Section 334 (g) of Public Law 95-216 provides that:

> "(1) The amendments made by the preceding provisions of this section shall not apply with respect to any monthly insurance benefit payable, under subsection (b), (c), (e), (f), or (g) (as the case may be) of section 202 of the Social Security Act, to an individual—
>
> (A) to whom there is payable for any month within the 60-month period beginning with the month in which this Act is enacted (or who is eligible in any such month for) a monthly periodic benefit (within the meaning of such provisions) based upon such individual's earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218 (b)(2) of the Social Security Act); and
>
> (B) who at time of application for or initial entitlement to such monthly insurance benefit under such subsection (b), (c), (e), (f), or (g) meets the requirements of that subsection as it was in effect and being administered in January 1977."

In accordance with section 334 (g) of Public Law 95-216, the government pension reduction provision of section 202(b)(4) of the Act would not apply to the claimant's Wife's Insurance Benefits if two conditions were met. First, she must become entitled to a government pension within the 5-year period beginning with the month of enactment of Public Law 95-216 (December 1977). Second, at the time of her application, she must have met the requirements of entitlement to Wife's Insurance Benefits under subsection 202(b) of the Act as it was in effect and being administered in January 1977. The claimant meets the first requirement in that a government pension was payable to her within 60 months of December 1977. However, she does not meet the second requirement because she was not married for 20 years, which was required for divorced wife entitlement under section 216(d)(1) of the Act as it was in effect and being administered in January 1977. Consequently, the claimant does not qualify for the exception to the offset provision contained in section 334(g) of Public Law 95-216. Therefore, the Appeals Council found that the Wife's Insurance Benefits payable to her as a divorced wife are subject to government pension reduction.

SECTION 203(b) and (f) (42 U.S.C. 403(b) and (f)) WORK DEDUCTIONS—EARNINGS OF A CORPORATE OFFICER—EXTENT AND VALUE OF SERVICES

20 CFR 404.415 and 404.430 **SSR 82-16**

The claimant became entitled to Old-Age Insurance Benefits beginning June 1980. On the basis of his estimated 1980 earnings of $30,000, SSA informed him that his benefits for 1980 would be subjected to work deductions for each month in which he earned wages of more than $417 or performed substantial services in self-employment. He subsequently alleged that, beginning July 1980, the corporation for which he was an officer and principal stockholder would pay him a salary of $417 per month plus dividends as a stockholder. SSA determined that his alleged stock dividends should be charged as excess earnings because they were in fact wages for his services as an employee. On appeal, it was established that before July 1980, the claimant worked full-time for the corporation and was paid a salary of $2,064 per month. Beginning in July 1980, his services for the corporation were greatly curtailed and his duties were largely assumed by his son and another employee who was promoted. *Held*, the services performed by the claimant since July 1980 were commensurate with his $417 monthly salary; therefore, the dividends which he received since then did not constitute wages for work deduction purposes.

The issue is whether the claimant had wages of more than $417 per month or performed substantial services in self-employment since becoming entitled to Old-Age Insurance Benefits. Resolution of this issue is necessary to determine if the claimant's benefits are subject to work deductions.

The evidence of record indicates that the claimant, who attained age 65 on June 20, 1980, filed an application for Old-Age Insurance Benefits on April 30, 1980. In his application, the claimant indicated that he expected his total earnings for 1980 to be $30,000, and further indicated that he would earn more than $417 per month in employment or perform substantial services in self-employment in all the months in 1980. The claimant's wife also stated in writing that she did not wish to file for Wife's Insurance Benefits on his earnings record because he was not retiring. On May 9, 1980, SSA advised the claimant that, because of his estimated earnings for 1980, he would not be due any benefits for that year.

On July 25, 1980, the claimant stated in writing that when he had estimated his 1980 income in his application for benefits, he had included investment income from his business. He further stated that, as of July 1, 1980, he had reduced his work activity and that his son would head up the business. He also stated that his son and another employee whom they were promoting would take over his duties. The claimant's daily work activities were reduced to coming to the office each morning, approximately four days a week, where he would drink coffee, look over the mail, and decide what errands he wanted to run. He would then leave around noon or a little thereafter. The claimant's monthly salary, beginning with July 1, 1980, was $417 (the monthly exempt amount applicable to taxable years ending in 1980).

The claimant owns 93% of the stock of the business in question. His son owns the remaining shares. The business, a corporation carrying the claimant's name, primarily processes advertising through the mail and sells specialty office-type items. Besides the claimant, the business employs seven employees. The claimant was president of the company and his son was vice president. The claimant alleges that prior to July 1, 1980, he worked full-time in the business and was paid a salary of $2,064 per month. The evidence of record reflects that after July 1, 1980, the claimant received from the corporation $417 per month as an employee and dividends as a stockholder.

If both the claimant's salary and dividends are charged against him as wages under the Act, then clearly, he should be charged with excess earnings and would not be due Old-Age Insurance Benefits as of July 1980. It was the claimant's contention, however, that the dividends are not chargeable to him as wages. Nevertheless, SSA found that the claimant was not due benefits as of July 1980 because he had failed to reduce his involvement with the corporation to the extent that the true value of his services was correctly reflected by his $417 monthly salary.

Section 202(a) of the Act provides for the payment of Old-Age Insurance Benefits to a person who meets certain requirements.

Section 203(b) provides for the imposition of deductions against benefits for months in which an individual is charged with excess earnings under the Act.

Section 203(f) provides rules for the charging to the benefits of specific months amounts of excess earnings. This section provides that excess earnings will not be charged to (i.e., cause loss of) benefits in any month in which the individual did not engage in self-employment and did not render services for wages of more than the applicable exempt amount. This section also provides that there is a presumption than an individual has been engaged in self-employment in a month until it is shown that he or she did not render substantial services in such month with respect to any trade or business. A similar presumption applies to earnings from wages; it is presumed, with respect to any month, that an individual rendered services for wages of more than the applicable exempt amount until the contrary is shown.

It is evident from the record that on July 1, 1980, and thereafter, the claimant has attempted to rearrange his business affairs in a manner to achieve maximum return from the corporation as well as to receive full monthly Old-Age Insurance Benefits under the Act. There is, of course, nothing wrong in this as a person may properly arrange his business, personal, and professional affairs so as to receive full benefits under the Act. However, it must be remembered that the benefits in question are retirement benefits, and it is the intent of the Act that the beneficiary be retired within the meaning of the Law to be eligible for the full monthly cash benefits. The Law does not require a beneficiary to retire completely to qualify for benefit payments, and significant employment may be engaged in before all monthly benefits are subject to deductions. The intent and wording of the Act cannot be circumvented, however, by arrangements whereby reported earnings are substantially less than the value of the services performed, and the real value of the services are received as remuneration in a different manner. One court has held, for instance, that a corporate officer may not by a "scheme of shifting wages" indirectly receive remuneration in another form which is in effect wages to him in order to avoid deductions for excess earnings under the Act (see SSR 63-40c (C.B. 1960-1965)).

In the instant case, the question presented is whether the dividends that the claimant receives from his 93% ownership of the corporation are really wages paid to him for the true value of his services performed as a corporate officer. Stated in a different manner, can the claimant, as a corporate officer and principal stockholder in the corporation, set his salary at a level allowed by Law to be eligible for full benefits and make up the difference between his new salary and prior salary by having remuneration for his services paid in the form of dividends. If the preponderance of the evidence establishes that this is what the claimant has done, then the claimant is not due benefits because his work activity is such that he has not met the conditions of retirement.

Under the Act, an officer of a corporation is defined as an employee (section 210(j)). Since the claimant is an employee, then the remuneration that he receives for services performed is considered wages and not income from self-employment. Under the Act, dividends received from stock ownership are excluded in determining net earnings from self-employment (section 211(a)(2)). However, as previously pointed out, dividends that are used to remunerate a corporate officer for the value of his services cannot escape being classified as wages. If the value of the claimant's services are commensurate with the $417 per month he receives as a salary from the corporation, then the dividends he receives are not considered remuneration for services rendered.

The evidence of record indicates that the claimant was in a position to set, and did set, the amount of his salary. The evidence must be evaluated though to see if the claimant actually resticted his work activities as of July 1, 1980, to a point whereby his $417 monthly salary was actually the true value of the services he performed. If so, then the claimant should be considered retired under the Act. In deciding whether the value of the services performed by the claimant are commensurate with his monthly salary, SSA looked to the evidence to see what services the claimant actually performed as of July 1, 1980. If he has been active in the management and operation of the corporation, which he has developed over a number of years into an apparently successful operation, then his new salary would not truly reflect the value of his services, and the claimant could not be considered retired for purposes of the Act.

The evidence of record reflects that the claimant only spends a few hours each day at his place of employment. His aged mother lives nearby and he checks on her daily. The claimant testified that, for reasons of marital adjustment to retirement, it is actually better for him to get up and get out of the house each day and go the office. He testified that he devotes one day each week to volunteer services in the radiology department at one of the local hospitals. The testimony reflected that the claimant usually arrives at his office around 8:15 a.m., eats a light breakfast, and reads the newspaper. He then takes care of his and his mother's personal business, such as paying bills. The evidence reflects that the only work he did as an employee was to make deliveries to customers in a nearby radius of the office, which usually took around 30 minutes. The claimant testified that he took a long lunch period and left the office shortly thereafter.

The testimony at the hearing reflected that the claimant's duties have been greatly curtailed. His duties before July 1, 1980, have been assumed by his son and another employee recently promoted due to the claimant's retirement.

It is the claimant's employment setting that creates a question as to his retirement status. Undoubtedly, in his position, he can control his salary, duties, and other factors concerning his employment. However, it is because of his ability to control these factors that he can carefully arrange his affairs so as to receive maximum return from the corporation as well as full monthly Old-Age Insurance Benefits under the Act. The preponderance of the credible evidence supports the claimant's position that he has retired. Accordingly, the services performed by the claimant since July 1980 were commensurate with his $417 monthly salary. Therefore, the dividends that the claimant received from the business since July 1980 did not constitute remuneration for services rendered and thus were not earnings for deduction purposes. Consequently, the claimant has been retired within the meaning of the Act and due Old-Age Insurances Benefits since July 1980.

SECTIONS 203(b) and (f) and 211(a) and (c) (42 U.S.C. 403(b) and (f) and 411(a) and (c)) WORK DEDUCTIONS—TRADE OR BUSINESS—CONSULTING SERVICES

20 CFR 404.1066 **SSR 82-17c**

Grosswald v. Schweiker, 653 F 2d 58 (2nd Cir 1981)

> On July 1, 1978, the claimant, upon reaching age 65, simultaneously retired from his position as an executive for a bank and entered into a consulting agreement with the same bank. Under the terms of the contract, the claimant was hired as an independent contractor and paid $30,000 a year to provide consulting services exclusively for the bank. While under contract, the claimant did not hold himself out to any individual or institution other than the bank as available to render consulting services. The contract was terminated in February 1980. The Social Security Administration (SSA) determined that the claimant's earnings as a consultant were earnings from self-employment which completely offset his Old-Age Insurance Benefits for the period July 1978 through February 1980. The claimant appealed. He contended that, because he was under an exclusive contract with one company and did not hold himself out as available to render these same services to others, he was not engaged in a trade or business during that period within the meaning of section 162 of the Internal Revenue Code. Therefore, he maintained that his remuneration as a consultant was not net earnings from self-employment. In affirming SSA's determination, the court of appeals found that it made little sense to distinguish between a person who "holds himself out" to only one company (and agrees to provide services for no one else) and a person who "holds himself out" to more than one company. Consequently, the court *held* that, even though the claimant offered his services exclusively to his former employer, he was engaged in a trade or business and therefore his remuneration as a consultant constituted net earnings from self-employment for work deduction purposes under sections 203(b) and 211 of the Act.

OAKES, Circuit Judge:

This case raises the question in a Social Security context whether a former bank employee is engaged in a "trade or business" as that term is construed under section 162 of the Internal Revenue Code when he enters into a consulting agreement which provides that he can consult only for his former employer and not for others. The Tax Court has answered the question negatively in a tax context in *Barrett v. Commissioner*, 58 T.C. 284 (1972), relying on Justice Frankfurter's formulation in his concurring opinion in *Deputy v. du Pont*, 308 U.S. 488, 499 (1940), that " 'carrying on any trade or business,' within the contemplation of [section 162], involves holding one's self out to others as engaged in the selling of goods or services." Appellant argues to us, as he did to the court below, that "others" cannot include the singular "another." We agree with the United States District Court for the Eastern District of New York, Jack B. Weinstein, Chief Judge, that one who holds himself out to another—here, the bank for which he formerly had worked—as engaged in the selling of goods or services, is carrying on a "trade or business" within the meaning of section 162 of the Internal Revenue Code, and therefore also for purposes of Social Security retirement insurance benefits, under 42 U.S.C. § 411. Accordingly we affirm the district court's decision denying review of the determination of the Social Security Administration that, because of his net earnings from self-employment as exclusive consultant to the bank, appellant was not entitled to Social Security retirement benefits.

The facts are not in dispute. On July 1, 1978, appellant, upon reaching the age of 65, retired from his position as administrative vice president and senior lender for the Sterling National Bank and simultaneously entered into a consulting agreement with the bank. Pursuant to that agreement, in which appellant was denominated "an independent contractor," he was paid $30,000 per annum to perform "special consulting services" for Sterling, and Sterling only. This he did, until the contract was terminated in February 1980, and during that time he did not hold himself out to any individual or institution other than Sterling as available to render banking or other services. The Social Security Administration refused to pay appellant retirement benefits for the period July 1978 through February 1980, finding that his benefits had been completely offset by his excess earnings from self-employment. Grosswald's contention is that he was not in a "trade or business" during that period and that therefore his remuneration did not constitute "net earnings from self-employment" which may be offset against Social Security retirement benefits.

The statutory structure, while seemingly complicated, is really quite simple. Only "excess earnings"—not dividends, interest, or other forms of income—are offset against retirement benefits, under 42 U.S.C. § 403(b). "Excess earnings" consist of 50% of either "wages for services rendered" or "net earnings from any self-employment" that are above certain statutory limits, exceeded here. *See id.* § 403(f)(3), (5). The Social Security Administration determined, and the parties do not dispute, that Grosswald was not an employee earning "wages" after July 1978. Rather, the statutory issue is whether the $30,000 per annum consulting contract remuneration constituted "net earnings from self-employment." That term is defined in 42 U.S.C. §§ 411(a) as the gross income, minus deductions, "derived by an individual from any trade or business carried on by such individual." For the meaning of "trade or business," 42 U.S.C. § 411(c) refers us to the use of the term in section 23 of the Internal Revenue Code of 1939, which corresponds to section 162 of the Internal Revenue Code of 1954.[1] However, "trade or business" is not defined in section 162 or elsewhere in the Internal Revenue Code. It is a term of art which has many different applications in the Code and which has had various meanings depending on time and context. See 4A Mertens, *Law of Federal Income Taxation* § 25.08 (1979); 5 Mertens, *supra*, § 28.31.

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[1] 26 U.S.C. § 162 provides in part:

(a) In general

There shall be allowed as a deduction all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business . . . .

Section 162 corresponds to section 23(a)(1)(A) of the 1939 Code. *See* 26 U.S.C. § 7852(b) (references to 1939 Code in other statutes shall be deemed to be references to corresponding sections of 1954 Code); 20 C.F.R. § 404.1066 (1980); *Clevenger v. Weinberger*, 375 F. Supp. 821, 823 (W.D. Mo. 1974).

Preliminarily, we note in passing the Secretary's contention that "trade or business" in the Social Security Act might have a different meaning under that act than it has under the Internal Revenue Code. The Secretary argues in his brief that the term "is not defined solely by resort to Tax Court decisions" but rather must be examined "in the Social Security context." However persuasive such an argument might be in other situations, we are not persuaded by it in this case, where there is an explicit incorporation of the Internal Revenue Code by the Social Security Act, *see* 42 U.S.C. § 411(c). Presumably the Secretary makes this argument because the Tax Court decisions, or at least some of them, do run against his position. But however much weight those cases may be entitled to, and they are certainly deserving of our most serious consideration, they are not binding upon us. And, to the extent that they hold that a consultant is not engaged in a "trade or business" when he is working exclusively for one concern, we disagree with them.

The theory that a person can be deemed to be carrying on a "trade or business" only if he "holds himself out" to the public by offering goods or services originated in Justice Frankfurter's concurring opinion in *Deputy v. du Pont*, 308 U.S. 488 (1940). There, speaking to the difference, for tax purposes, between expenses incurred in conducting a "trade or business" and those incurred in managing one's own investments or in other profit-seeking activity, Justice Frankfurter said:

> To avail of the deductions allowed by § 23(a) [now § 162], it is not enough to incur expenses in the active concern over one's own financial interest. ". . . carrying on any trade or business," within the contemplation of § 12(a), involves holding one's self out to others as engaged in the selling of goods or services. This the taxpayer did not do. Expenses for transactions not connected with trade or business, such as an expense for handling personal investments, are not deductible.

Id. at 499. Several circuit court and Tax Court cases have developed Justice Frankfurter's language, which, even though it was a single justice's opinion, has been taken by at least one commentator to constitute the opinion of the Supreme Court. 5 Mertens, *supra*, § 28.31, at 123 & n.9. In view of the Supreme Court. In *Stanton v. Commissioner*, 399 F.2d 326, 329-30 (5th Cir. 1968), for example, the court, citing Justice Frankfurter's language, held that the taxpayer could not deduct certain expenses under section 162 because his "irregular and sporadic" efforts as an inventor did not rise to the level of "trade or business." And in *McDowell v. Ribicoff*, 292 F.2d 174, 177-78 (3d Cir.), *cert. denied*, 368 U.S. 919 (1961), citing the same language, the court held that the taxpayer's activities as executrix of her aunt's estate did not constitute a "trade or business." On the same reasoning, the Tax Court has held that a professional gambler—even though he gambled regularly, with a profit motive, and used his winnings to support his family—was not in a "trade or business" because he was not holding himself out to others as engaged in the selling of goods or services. *Gentile v. Commissioner*, 65 T.C. 1 (1975).

The Tax Court case closest to ours, however, is *Barrett v. Commissioner*, 58 T.C. 284 (1972). That case involved an executive officer whose employment contract provided that upon completion of his full-time services he would be paid $12,000 a year on the condition that he both render advisory and consulting services to the employer whenever reasonably requested and not compete with the employer—a contract essentially the same as appellant Grosswald's in the instant case. The issue in *Barrett* was whether the taxpayer owed self-employment tax under section 1401 of the Code, which, like the Social Security retirement benefits provision at issue here, incorporates by reference the interpretation of the term "trade or business" as it is used in section 162 of the Code, see 26 U.S.C. § 1402 (c). The Tax Court looked to the terms of Barrett's contract and, relying on Justice Frankfurter's concurring opinion in *Deputy* and the *McDowell* case, held that, because the noncompetition clause prohibited Barrett from offering his services "to others," he was not engaged in a "trade or business." 58 T.C. at 289-90.[2] *Barrett* was distinguished in the subsequent case of *Barnett v. Commissioner*, 69 T.C. 609 (1978), where the Tax Court held that a bank executive who had retired and simultaneously entered into a $1,000 per month consulting contract, which prohibited him from rendering similar services to any business that competed with the bank, was engaged in a "trade or business." The court explained that this was because the consulting contract apparently allowed the taxpayer to render services to banks in towns other than the one in which the employing bank was located, and the taxpayer had not proved that he had *not* held himself out to such other banks. In other words, to prove that he was not engaged in a "trade or business," the taxpayer had to demonstrate either that he was contractually prohibited from holding himself out to other banks or that he did not in fact do so. *Id.* at 613. Appellant Grosswald here clearly falls within *Barrett* rather than *Barnett*, not only because his contract prevented him from holding himself out to banks other than Sterling, but also because he in fact proved beyond peradventure that he did not do so and that he rendered his services exclusively during the period in question to Sterling.

Nevertheless, in our view *Barrett* was erroneously decided. It makes little sense to distinguish between a person who "holds himself out" to only one employer (and agrees to work for no one else) and a person who "holds himself out" to more than one employer. Justice Frankfurter surely did not intend such a distinction, even though he referred to "others" in his *Deputy* opinion; rather, it is clear that he was distinguishing between managing one's own investments and rendering services or selling goods to one or more others. We simply do not see the logic of the *Barrett* distinction. Nothing in the Code suggests it. Nothing in the case law of courts other than the Tax Court leads to such a result.[1]

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[2] The fact that Barrett actually had not rendered any consulting services to the company, and had not been requested to do so, was immaterial to its holding, the court said. *Barrett v. Commissioner*, 58 T.C. 284, 289 (1972).

While we cannot say that the theory of *Barrett* is "as thin as the homoeopathic soup that was made by boiling the shadow of a pigeon that had been starved to death," *see Beamsley v. Commissioner*, 205 F.2d 743, 748 (7th Cir. 1953) (attributed to Abraham Lincoln), we have to say that we find it unpalatable.

Judgment affirmed.

SECTIONS 204(a) and (b) (42 U.S.C. 404(a) and 404(b)) OVERPAYMENT—WITHOUT FAULT—WAIVER OF RECOVERY AND ADJUSTMENT

20 CFR 404.506, 404.507, and 404.511 **SSR 82-18a**

> After being informed that he had been overpaid for 1976 and 1977 due to his excess earnings, the claimant, an Old-Age Insurance beneficiary, appealed, arguing that because he had filed timely annual reports of his earnings for 1976 and 1977 he was without fault in causing the overpayment for those years. He further contended that he was unaware of the need to notify SSA earlier than he did. The record showed, however, that the claimant had incurred overpayments in both 19 and 1974 and should have understood that failure either to notify SSA promptly about excess earnings or to return benefit checks would result in an overpayment. Furthermore, beneficiaries are periodically reminded by enclosures with their checks and by the media that if they expect to have excess earnings for a year they should notify SSA during that year. *Held*, the claimant was at fault in causing the overpayment for 1976 and 1977; consequently, recovery of the overpayment could not be waived.

The claimant became entitled to OAIB effective April 1971 and returned to part-time work in 1973. He filed an annual report of his 1973 earnings on April 15, 1974, and did not contest the $238 overpayment assessed for that year. In 1976, the claimant had excess earnings, but did not notify SSA of these excess earnings until after all 1976 benefit checks had been sent to him. In September 1977, he provided SSA with an estimate of his earnings for 1977. However, his actual earnings for that year exceeded his estimate and an overpayment resulted. SSA determined that the claimant was not without fault in causing the overpayment for 1976 and 1977, and that, therefore, recovery of the overpayment could not be waived.

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[1] Appellant here relies upon *Snow v. Commissioner*, 416 U.S. 500 (1974), which concerns the deductibility under section 174(a)(1) of the Code of "experimental expenditures paid or incurred in connection with [a] trade or business." It is true that the Court in *Snow* did refer to Justice Frankfurter's concurring opinion in *Deputy v. du Pont*, 308 U.S. 488, 499 (1940), but the Court expressly distinguished section 174(a)(1) from section 162(a), considering that the latter is "more narrowly written" and that section 174 was enacted "to dilute some of the conception of 'ordinary and necessary' business expenses under § 162(a) [as] adumbrated by Mr. Justice Frankfurter." 416 U.S. at 502-03. Section 162 and the other 60 or so sections of the 1954 Code referring to "trade or business" were thought, in Justice Douglas's opinion for the *Snow* Court, to be "not helpful." The reference to *Snow* under these circumstances seems hardly apposite, much less helpful to appellant.

Throughout the administrative appeal process, the claimant argued that he was without fault in causing the overpayment for 1976 and 1977 because he had filed annual reports of his earnings with SSA by April 15th of each of the following years. He further argued that he was not aware until August 1977 of the need to notify SSA during a year regarding the extent of his earnings for such a year so that his benefits could be adjusted and an overpayment prevented.

Section 204(a) of the Act provides, in part, that whenever an incorrect payment has been made, recovery or adjustment of the incorrect payment shall be made.

Section 204(b) of the Act and §404.506 of Regulations No. 4 provide that in any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery from, any person who is without fault if such adjustment or recovery would defeat the purpose of title II of the Act or would be against equity and good conscience.

Section 404.507 of Regulations No. 4 provides, in part, that—

> "In determining whether an individual is at fault, the Administration will consider all pertinent circumstances, including his age, intelligence, education, and physical and mental condition. What constitutes fault...on the part of the overpaid individual... depends upon whether the facts show that the incorrect payment to the individual...resulted from:
>
> (a) An incorrect statement made by the individual which he knew or should have known to be incorrect; or
> (b) Failure to furnish information which he knew or should have known to be material; or
> (c) With respect to the overpaid individual only, acceptance of a payment which he either knew or could have been expected to know was incorrect."

Section 404.511 of Regulations No. 4 provides that fault exists if an incorrect payment arose from a lack of good faith or a failure to exercise a high degree of care in determining whether circumstances which may cause deductions from benefits should be brought to the attention of SSA by an immediate report or by return of a benefit check. The high degree of care expected of an individual may vary with the complexity of the circumstances giving rise to the overpayment and with the capacity of the particular individual to realize that he or she is being overpaid.

The claimant's argument that he was "without fault" in causing the overpayment was based essentially on the premise that as long as an individual files a report of his or her earnings for a year by April 15th of the following year, he or she cannot be said to be at fault in causing an overpayment for that year. Where an individual files an annual report of excess earnings by April 15 of the following year, he or she has indeed complied with the statutory reporting requirement. This does not mean that the individual was without fault, however. Had SSA been informed early enough during the years in question of the extent of the claimant's earnings, his benefits could have been adjusted and the overpayment prevented. When an individual accepts benefits during a year on the assumption that his or her earnings will be less than they actually are, the individual cannot be said to be without fault in causing any overpayment which results from the inaccuracy of his or her assumptions.

The claimant had excess earnings in both 1973 and 1974 and should have been aware by 1976 that his failure to notify SSA promptly of the extent of his earnings or to return benefit checks during a year in which his earnings exceeded the applicable exempt amount would result in an overpayment. In addition, beneficiaries are periodically reminded by enclosures with their checks and by the media that they should notify SSA during the year if they anticipate excess earnings for that year. The claimant was obviously an educated person (he holds a doctorate in dentistry), and had the capacity to understand and comply with his responsibilities. Hence, there is no merit in the claimant's argument that he was unaware of the need to notify SSA during a year regarding the extent of his excess earnings for that year in order to prevent an overpayment.

Accordingly, it was held that the claimant was not without fault in causing the overpayment of OAIB made to him during 1976 and 1977, and that recovery of the overpayment could not be waived.

SECTIONS 205(b), (g), and (h) and 206(a) (42 U.S.C. 405(b), (g), and (h) and 406(a)) JUDICIAL REVIEW—ATTORNEY'S FEE FIXED BY ADMINISTRATION—CONSTITUTIONALITY

20 CFR 404.1720 and 404.1725 **SSR 82-19c**

Rahman v. Harris, (Transfer Binder, 10/80-07/81) Unempl. Ins. Rep (CCH) ¶17,212

When the Social Security Administration (SSA) authorized a fee for claimant's attorney, the claimant appealed, contending that the fee was excessive. The Social Security Act (the Act) and regulations do not provide for a hearing with respect to determinations made regarding an attorney's fee, and section 205(g) of the Act limits judicial review to final decisions made by SSA after a hearing. Consequently, SSA claimed that the determination made regarding the attorney's fee was an administrative decision which was not subject to judicial review and moved for a dismissal of the suit. The claimant argued, however, that SSA's procedure for the assessment and review of an attorney's fee, which is set out in the regulations, had denied him due process and that some of the steps in the procedure had not been followed. In view of Section 205(g) of the Act, the court found that, absent a constitutional question, it did not have jurisdiction over a fee authorized by SSA. As to the claimant's constitutional argument, the court found that SSA's procedure for the assessment and review of attorneys fees was sufficient to satisfy due process because all interested parties had a chance to put their views before the decision maker. Finally, the court found that, despite the procedural missteps, the record showed that the claimant had been given a full and fair opportunity to present his position with respect to the attorney's request for a fee. Accordingly, in granting SSA's motion for a dismissal, the court *held* that the claimant's contention that he had been deprived of his constitutional rights was without merit.

JOINER, District Judge:

Plaintiff applied for and eventually received disability benefits under Subchapter II of the Social Security Law, 42 U. S. C. § 401 *et seq.* Following the decision by the Secretary of Health, Education and Welfare to grant these benefits to the plaintiff, the attorney who represented plaintiff before the secretary asked the secretary to award him attorney's fees for the work he did in securing the benefits for the plaintiff. The secretary did make such an award.

Plaintiff, believing that the secretary erred in making the award, filed this suit in an attempt to have the award set aside. The secretary, claiming that this court has no jurisdiction over the issues in this suit, has moved for an order of dismissal. The secretary simply asserts that the case law is clear that a court has no jurisdiction when an attorney appeals from a ruling relative to attorney's fees and that the same rule should apply when the claimant appeals from an allegedly excessive award. For the reasons that follow, the motion is granted.

Since the issue presented involves the power of the district court to decide suits arising out of decisions by the secretary, it is helpful to examine the framework of this power.

Title 42 of the United States Code, Section 405(g) (hereafter 405(g)), is the section of the Social Security law which provides for judicial review in some circumstances. It provides in part that:

> Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action . . . [in the district court of the United States].

Title 42 of the United States Code, Section 405(h), provides that the limited review that is permitted by 405(g) is the only judicial review that may be had under this subchapter. The Supreme Court has held that this limitation on judicial review is absolute and that not even the Administrative Procedure Act provides an additional avenue of judicial review. *Califano v. Sanders*, 430 U. S. 99 (1977).

Therefore, it is clear that if this court has jurisdiction over the case at bar, it must be that the suit is authorized by 405(g).

Plaintiff agrees with the position of the secretary that there was no "hearing" at the administrative level in this case. Plaintiff disagrees, however, with the secretary's argument that this lack of a hearing is fatal to the plaintiff's assertion that the district court has jurisdiction over this suit.

The wording of 405(g) is such that the secretary's position is a compelling one. However, in *Caifano v. Sanders, supra*, the Supreme Court held that despite the wording of that jurisdictional subsection, the district courts do have jurisdiction to hear claims that the secretary has deprived applicants of constitutional rights. "When constitutional questions are in issue, the availability of judicial review is presumed, and we will not read a statutory scheme to take the 'extraordinary' step of foreclosing jurisdiction unless Congress' intent to do so is manifested by ' "clear and manifesting" ' evidence." [citations omitted] 430 U. S. at 109.

The court reads plaintiff's *pro se* complaint as presenting a constitutional question. Therefore, the court is not without jurisdiction to determine the issues involved.

In support of the motion to dismiss, the secretary cites to a number of cases in which attorneys who had represented applicants before the secretary and who had asked the secretary to award attorney's fees to them for this representation unsuccessfully attempted to have the courts overturn what the attorneys believed were unsupportably low awards. *Chernock v. Gardner*, 360 F. 2d 257 (3rd Cir. 1966); *Fenix v. Finch*, 436 F. 2d 831 (8th Cir. 1971); *Schneider v. Richardson*, 441 F. 2d 1320 (6th Cir.), *cert. denied* 404 U. S. 872 (1971); *Copaken v. Califano*, 590 F. 2d 729 (8th Cir. 1979).

Each of these cases held that the district court had no power to overturn such an award upon a finding that the secretary had abused her discretion. To the extent that plaintiff seeks to make a similar claim, this court holds that he is in no better position than the attorneys to raise such an issue.

While an applicant may have some rights to judicial review which are not available to an attorney representing an applicant, none of those would benefit him in this situation since the decision on a request for an attorney's fee is not one which triggers the right to a hearing under 405(b), and since the applicable regulations do not provide for a hearing for either the attorney or the applicant. See *Copaken, supra*.

Plaintiff alleges more than this, however. He alleges that the proceedings which eventually led up to the final award of attorney's fees were such as to have denied him property (the money taken away from him and paid instead to his attorney) without due process of law.

In *Copaken v. Califano, supra*, an attorney made a similar claim. There, the court carefully looked at the procedure set out in the regulations for the handling of a request for attorney's fees, and it held that this procedure was sufficient to satisfy the rigors of constitutional due process despite the absence of any "hearing."

The procedure found to satisfy due process in *Copaken* is as follows:

1. After the secretary makes a decision which entitles an applicant to back benefits, an attorney desiring an award of fees must file a written petition asking therefor. 20 C.F.R. § 404.975(b).[1]

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[1] [Former] 20 C.F.R. § 404.975 provides:

(a) *General*. A fee for services performed for an individual before the Social Security Administration in any proceeding under titles II or XVIII of the Act may be charged and received only as provided in paragraph (b) of this section.

(b) *Charging and receiving fee*. An individual who desires to charge or receive a fee for services rendered for an individual in any proceeding under titles II or XVIII of the Act before the Administration (see § 404.977a), and who is qualified under § 404.972, must file a written petition therefor in accordance with § 404.976(a). The amount of the fee he may charge or receive, if any, shall be determined on the basis of the factors described in §404.976(b) by an authorized official of the appropriate component of the Administration, where the services were concluded by an initial, reconsidered, or revised determination, or by the Bureau of Hearings and Appeals where there is a decision or action by an Administrative Law Judge or the Appeals Council of the Social Security Administration, as the case may be. Every such fee which is charged or received must be approved as provided in this section and no fee shall be charged or received which is in excess of the amount so approved. This rule shall be applicable whether the fee is charged to or received from a party to the proceeding or someone else. Pursuant to section 206(a) of the Act, in the case of a representative qualified as an attorney under § 404.972(a), the Administration may certify the amount of such fee, subject to the limitations in § 404.977(b), for payment out of, but not in addition to, the amount of past-due benefits payable.

(c) *Past-due benefits defined*. The term "past-due benefits" as used in paragraph (b) of this section means the total accumulated amount of benefits payable under title II of the Act by reason of the favorable determination through the month prior to the month such determination is effectuated.

(d) *Notice of fee determination*. Written notice of a fee determination made in accordance with paragraph (b) of this section shall be mailed to the representative and the claimant at their last known addresses. Such notice shall inform the parties of the amount of the fee authorized, the basis of the determination, the fact that the Administration assumes no responsibility for payment except that pursuant to section 206(a) of the Act the Administration may certify payment to an attorney, and that each party may request an administrative review of the determination within 30 days of the date of the notice.

(e) *Administrative review of fee determination*. (1) *Request timely filed*. Administrative review of a fee determination will be granted if either the representative or the claimant files a written request for such review at an office of the Social Security Administration within 30 days after the date of the notice of the fee determination. The party requesting the review shall send a copy of the request to the other party. An authorized official of the Administration who did not participate in the fee determination in question will review the

2. The written petition must include, among other things, "[A] statement showing that a copy of the petition was sent to the person represented." See 20 C. F. R. § 404.976(a)(7).[2]

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determination. Written notice of the decision made on the administrative review shall be mailed to the representative and the claimant at their last known addresses.

(2) *Request not timely filed.* Where the representative or the claimant files a request for administrative review, in accordance with paragraph (e)(1) of this section, but more than 30 days after the date of the notice of the fee determination, the person making the request shall state in writing the reasons why it was not filed within the 30-day period. The Social Security Administration will grant the review only if it determines that there was good cause for not filing the request timely. For purposes of this section, "good cause" is defined as any circumstance or event which would prevent the representative or the claimant from filing the request for review within such 30-day period or would impede his efforts to do so. Examples of such circumstances include the following:

(i) The representative or claimant was seriously ill or had a physical or mental impairment and such illness prevented him from contacting the Social Security Administration in person or in writing;

(ii) There was a death or serious illness in the individual's family;

(iii) Pertinent records were destroyed by fire or other accidental cause;

(iv) The representative or claimant was furnished incorrect or incomplete information by the Social Security Administration about his right to request review;

(v) The individual failed to receive timely notice of the fee determination;

(vi) The individual transmitted the request to another government agency in good faith within such 30-day period and the request did not reach the Social Security Administration until after such period had expired.

The Social Security Administration assumes no responsibility for the payment of a fee based on a revised determination where the request for administrative review was not filed timely. (See § 404.977(b) for payment of attorney fees authorized by the Administration.)

[2] [Former] 20 C. F. R. § 404.976 provides:

(a) *Filing of petition.* In accordance with § 404.975, to obtain approval of a fee for services performed before the Social Security Administration in any proceeding under the Act, a representative, upon completion of the proceedings in which he rendered services, must file at an office of the Social Security Administration a written petition which shall contain the following information:

(1) The dates his services began and ended;

(2) An itemization of services rendered by him in a proceeding under the Act, with the amount of time spent in hours, or parts thereof, on each type of service;

(3) The amount of the fee he desires to charge for services performed;

(4) The amount of fee requested or charged for services rendered in the same matter before any State or Federal court;

(5) The amount and itemization of expenses incurred for which reimbursement has been made or is expected;

(6) The special qualifications which enabled him to render valuable services to the claimant (this requirement does not apply where the representative is an attorney); and

(7) A statement showing that a copy of the petition was sent to the person represented.

(b) *Factors considered in evaluating a petition for fee.* In evaluating a request for approval of a fee, the purpose of the social security program—to provide a measure of economic security for the beneficiaries thereof—will be considered, together with the following factors:

(1) The services performed (including type of service);

(2) The complexity of the case;

(3) The level of skill and competence required in rendition of the services;

(4) The amount of time spent on the case;

(5) The results achieved. (While consideration is always to be given to the amount of benefits, if any, which are payable in a case, the amount of fee will not be based on the amount of such benefits alone but on a consideration of all of the factors listed in this section. The benefits payable in a given claim are governed by specific statutory provisions and by the occurrence of termination, deduction, or nonpayment events specified in the

3. When the initial decision on the petition is made, the secretary is to notify both the applicant and the representative (attorney) of the decision. This notice must include a statement advising the applicant and that representative that either may appeal the decision within the agency by a written request to do so filed within 30 days. 20 C. F. R. § 404.975(d), (e).

4. Any person (applicant or representative) who decides to appeal the initial determination must serve a copy of the request for review upon the other party. 20 C. F. R. § 404.975(e).

5. When the proper decision maker within the agency has determined the appeal, notice of this final decision is sent to the parties. 20 C. F. R. § 404.975(e).

This court agrees that the system is sufficient to satisfy due process. Even though there is no provision for a hearing, all interested parties have a chance to put their views before the ultimate decision maker. To provide full hearings on these petitions would be to divert too many of the agency's resources from the substantive tasks it is called upon to perform. See *Copaken, supra*.

The determination that the system as set out in the regulations satisfies due process does not end the inquiry. In this case, plaintiff claims that some of the steps in the system were not followed and that the failures amounted to a denial of due process. As the court in *Copaken* noted, this system is a good one, but it is good only when it is carried out fully.

Plaintiff claims that he never received a copy of the attorney's initial petition for attorney's fees (see Step 2). He further complains that he did not receive a copy of either the initial determination by the secretary (see Step 3) or the attorney's subsequent request for review of this initial determination (see Step 4).

If all of these claims turned out to be true, and if, as a result, plaintiff was denied a full and fair opportunity to put his position before the decision maker, this court would be compelled to find a denial of plaintiff's right to due process.

In this case, however, plaintiff, in his own complaint, has made it evident that whatever failures there may have been, the secretary, by providing the plaintiff with an additional opportunity to present his arguments, has cured the defects and provided plaintiff with due process.

Paragraph 8 of the plaintiff's complaint indicates that plaintiff received a letter from the secretary, which letter informed the plaintiff (1)

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law, factors which are unrelated to efforts of the representative. In addition, the amount of accrued benefits payable in a given claim is affected by the length of time that has elapsed since the claimant became entitled to benefits.);

(6) The level of administrative review to which the claim was carried within the Social Security Administration and the level of such review at which the representative entered the proceedings; and

(7) The amount of the fee requested for services rendered, excluding the amount of any expenses incurred, but including any amount previously authorized or requested.

that plaintiff's attorney had petitioned for an award of attorney's fees; (2) that that petition had been granted in part; (3) that the attorney had appealed that decision; and (4) that plaintiff would be given an opportunity to respond to the claims made by the attorney on appeal.

This letter does not appear to be a part of the ordinary procedure under the regulations. However, even if the regulations themselves were violated, the question remains whether or not the plaintiff's rights to due process of law were violated. This is a question of fairness and the entire context must be considered. *United States v. Caceres*, 440 U. S. 741 (1979). If this letter provided a fair opportunity to the plaintiff to present his position to the decision maker, any missteps in the procedure as it is set out in the regulations would have been harmless ones.

Paragraph 10 of the plaintiff's complaint, along with Exhibit E to that complaint, shows (1) that the plaintiff did submit a letter regarding the attorney's appeal to the secretary, and (2) that the secretary did consider that submission in making the determination of the appeal.

Thus, it is clear that, despite the claimed procedural missteps, plaintiff was given a full and fair opportunity to present his position with respect to the attorney's request for fees. It is also clear that this position was in fact articulated to and considered by the decision maker prior to the final decision. For this reason, the court finds that any failure of either the secretary or the attorney to comply with the regulations was harmless as a matter of law, and that there is no merit to the constitutional claim of the plaintiff. Therefore, the secretary's motion is granted

So ordered.

SECTION 205(c) (42 U.S.C. 405(c)) SELF-EMPLOYMENT INCOME—CORRECTION OF EARNINGS RECORD AFTER EXPIRATION OF TIME LIMITATION

20 CFR 404.803(c)(3) **SSR 82-20c**

Yoder v. Harris, 650 F. 2d 1170 (10th CIR. 1981)

Although the claimant alleged that he was a self-employed dairy farmer from 1964 through 1971, no self-employment income (SEI) was posted to his earnings record for those years. Section 205(c)(4)(C) of the Social Security Act (the Act) provides that the absence of an entry in the Social Security Administration's (SSA) records of SEI for a year is conclusive evidence that the person did not derive SEI in that year. However, if a self-employment (SE) tax return was filed for such a year before the expiration of the time limitation provided in the Act (3 years, 3 months, and 15 days after the taxable year in which the SEI alleges to have been derived), SSA will correct its records to include the SEI derived by the person for that year. In the claimant's case, he failed to file timely income tax returns for the years in question. Forms 1099 (United States Informational Returns), however, were timely filed by various farm cooperatives for 1964 through 1971 showing payments made to the claimant. A district court found that they constituted SE tax returns for purposes of correcting the claimant's earnings record under section 205(c)(5)(F) of the Act. Consequently, the district court ordered that the claimant's earnings record for 1964 through 1971 be credited with SEI in the amounts shown on Forms 1099. In reversing the district court, the court of appeals found that Forms 1099 failed to establish that the claimant had net SEI for the relevant years because they showed only the gross amounts paid to him and did not reflect his expenses or losses. Accordingly, the court of appeals *held* that Forms 1099 did not constitute SE tax returns for purposes of section 205(c)(5)(F) of the Act. It *further held* that the claimant may prove that he had SEI during those years for which SSA's records show none only from information filed with timely filed income tax returns.

LOGAN, Circuit Judge:

The Secretary of Health, Education, and Welfare appeals a decision of the district court that requires crediting Henry D. Yoder with self-employment income for the years 1962 through 1971 for social security purposes. The issue on appeal is the correctness of the trial court's determination that information on certain United States Information Returns, Forms 1099, filed by various farm cooperatives showing payments to Yoder, qualify as tax returns filed with the Commissioner of Internal Revenue for Social Security Act purposes under 42 U.S.C. § 405(c)(5)(F).

By agreement the case was submitted on the pleadings, briefs, and certified transcript of the record before the Social Security Administration. Yoder sought to establish his eligibility for medicare benefits. Review disclosed that Yoder's social security earnings record contained no entries from 1961 through 1973 and that he had not filed United States income tax returns for the years 1962 through 1974. At the time of his application, Yoder was being audited by the Internal Revenue Service (IRS) which ultimately required him to file delinquent tax returns for all of those years. Both parties apparently agree that 42 U. S. C. § 405(c) prohibits use of the delinquent income tax returns to credit Yoder's account with self-employment income for the years 1962 through 1971 since such returns were not timely filed.

Yoder claims to have been a self-employed dairy farmer between 1964 and 1971, and various farm cooperatives filed with the IRS timely United States Information Returns, Forms 1099 for those years showing patronage dividends paid to Yoder. The Social Security Administration held the Forms 1099 do not constitute tax returns of self-employment income under section 205(c)(5)(F) of the Act, 42 U. S. C. § 405(c)(5)(F), since they show only gross amounts paid to Yoder and do not establish that such amounts constituted net self-employment income. Upon review, the district court concluded the language in section 405(c)(5)(F), permitting the Secretary to amend his records to conform with "tax returns or portions thereof (*including information returns and other written statements*) filed with the Commissioner of Internal Revenue," is sufficiently broad to include the Forms 1099 filed by the farm cooperatives. (Emphasis added.) It reversed the final decision of the Social Security Administration and ordered that Yoder's earning records for the years 1964 through 1971 be credited with self-employment income in the amounts shown on the Forms 1099. This appeal followed.

[*Correction of Earnings Records; Applicable Law*]

The Secretary is required by 42 U. S. C. § 405(c)(2)(A) to "establish and maintain records of the amounts of . . . self-employment income derived by, each individual and of the periods in which . . . such income was derived." An individual's records are available to him and may be corrected if application is made within three years, three months, and fifteen days after the year in question. 42 U. S. C. §§ 405(c)(1)(B), 405(c)(4). However, once that time limitation has expired—as it has in this case—section 405(c)(5)(F) provides that the Secretary

> may change or delete any entry with respect to wages or self-employment income in his records of such year for such individual or include in his records of such year for such individual any omitted item of wages or self-employment income but only—
>
> . . .
>
> (F) to conform his records to—
>
> (i) tax returns or portions thereof (including information returns and other written statements) filed with the Commissioner of Internal Revenue.
>
> . . .
>
> except that no amount of self-employment income of an individual for any taxable year (if such return or statement was filed after the expiration of the time limitation following the

> taxable year) shall be included in the Secretary's records pursuant to this subparagraph.

If there has been no timely correction of the Secretary's records and no filing of tax returns, the Act creates a conclusive presumption that claimant had no self-employment income. 42 U. S. C. § 405(c)(4)(C).

The trial court relied on *Grigg v. Finch*, 418 F. 2d 661 (6th Cir. 1969), to hold the parenthetical "including information returns and other written statements" contained in section 405(c)(5)(F) entitles Yoder to have his social security records corrected to reflect information returned on Forms 1099 filed by the farm cooperatives. In *Grigg*, the Secretary denied disability benefits claimed by Harold Grigg, a part-time accordion instructor at the Detroit Conservatory of Music because Grigg's social security records showed quarters of coverage insufficient under 42 U. S. C. § 416(i)(3). The district court held that notwithstanding Grigg's failure to file income tax returns for the years in question, information returns, Forms 1099, filed by the conservatory, which included Grigg's name and social security number and indicated that Grigg had self-employment income from his services at the conservatory, were sufficient to give the Secretary actual or constructive knowledge under section 405(c)(5)(F) that Grigg had self-employment income during those years. The Sixth Circuit agreed stating that

> the "absence of an entry in the Secretary's records" referred to in § 405(c)(4)(C) means an "absence" which persists even after inclusions in the Secretary's records allowed by § 405(c)(5)(F), and that the Detroit Conservatory's information returns satisfied the requirements of § 405(c)(5)(F) ("tax returns or portions thereof (including information returns and other written statements) filed with the Commissioner of Internal Revenue * * *"), thereby giving the Secretary actual or constructive notice of Grigg's self-employment income for the years 1956 and 1957.

Id. at 664.

This view is also supported by *Maloney v. Celebrezze*, 236 F. Supp. 222 (N. D. Ohio 1964), which held that a claimant's tax return erroneously filed on a wage-earner's card form—the claimant should have filed a self-employment return—followed by an amended return filed five years later constituted a timely filed self-employment tax return for purposes of section 405(c)(4)(C). *Maloney* stressed that the phrase "a tax return of his self-employment income" found in section 405(c)(4)(C) must be read in light of the "much more flexible language of section 405(c)(5)(F) which permits the inclusion of omitted items of self-employment income to conform to a tax return, a *portion thereof*, or a *written statement* filed with the Commissioner of Internal Revenue." *Id.* at 225.[1] See *White v. Celebrezze*, 226 F. Supp. 584, 588 (E. D. Va. 1963),

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[1] The court excused Maloney's error in filing a 1040A wage return rather than a self employment income return since the IRS apparently gave Maloney, who was blind, the wrong form. While we agree with the beneficient result in *Maloney*, we do not agree with the court's loose construction of section 405(c)(5)(F).

("the language of § 405(c)(5)(F) is broader than that of § 405(c)(4)(C) because it specifically mentions 'portions' of a tax return and 'other written statements' as bases for changing the Secretary's records rather than referring to the tax return as a whole as § 405(c)(4)(C) does.")

[*Interpretation of Statute*]

With respect, we disagree with the interpretations of the language of section 405(c)(5)(F) by those courts. Congress did not insert the modifying parenthetical "including information returns and other written statements" after "portion thereof" unwittingly; rather it purposively drafted section 405(c)(5)(F) to be consistent with the language of section 405(c)(4)(C). Under section 405(c)(5)(F) the Secretary is only permitted to update his records based on information contained in a timely filed tax return or portions thereof, the parenthetical following "portions thereof" simply explains that portions of timely filed tax returns that may reveal self-employment income include information returns and other written statements. So construed, the language in section 405(c)(5)(F) is equivalent to the language in section 405(c)(4)(C) which requires proof that the claimant "filed a tax return of his self-employment income" in order to rebut the conclusive presumption created by an absence of information in the Secretary's records.

This construction of section 405(c)(5)(F) is consistent with the legislative history of the Act. That history indicates the principal factor in Congress' decision to include self-employed persons in the Social Security system was the development of a workable mechanism for determining earnings. Self-employed persons were not covered by social security prior to 1950 since "there was no agreement on a feasible method of obtaining . . . reports of their income." *Proposed Amendments to the Social Security Act: Hearings on H. R. 2892 Before the House Committee on Ways and Means*, 81st Cong., 1st Sess. 1084 (1949) (statement of Dr. Arthur Altmeyer). The Senate Report explained the reasons for extending coverage to the self-employed: "Practicable administrative procedures for coverage of the self-employed have been developed. An individual would report his self-employment income by transferring certain information from the trade or business schedule of his income-tax return to a social-security schedule on the same return." S. Rep. No. 1669, 81st Cong., 2d Sess. reprinted in [1950] U. S. Code Cong. & Ad. News 3299. The Commissioner for the Social Security Administration, testifying before the House Committee on Ways and Means, stated:

> The self-employed were excluded from the original program largely because, at that time, there was no agreement on a feasible method of obtaining such reports of their income. Subsequent developments have indicated that most self-employed persons can report their income, for purposes of coverage, as a part of their income-tax returns.

Hearings on H. R. 2893 Before the House Committee on Ways and Means, 81st Cong. 1st Sess. 1081, 1084 (1949) (statement of Dr. Arthur Altmeyer).

It is clear from the legislative history that the federal income tax reporting system enabled Congress to extend social security benefits to the self-employed.[2] As the Third Circuit correctly summarized in *Shore v. Califano*, 589 F. 2d 1232, 1238 (1978), "the creation of an administratively feasible mode for determining the eligibility of self-employed claimants was a paramount legislative concern in 1950. Reliance on income tax returns was regarded as the only workable plan." Congress accordingly adopted language in section 405(c)(4)(C) providing that the Secretary's records of self-employment income are conclusive after expiration of the statutory time limitation unless it is shown that the claimant filed an income tax return. Consistent language was adopted in section 405(c)(5)(F) which permits the Secretary to conform his records to "tax returns or portions thereof (including [as portions thereof] information returns and other written statements) filed with the Commissioner of Internal Revenue."

[*Forms 1099 Not "Tax Returns"*]

Forms 1099 filed by the farm cooperatives showing patronage dividends and interest paid to Yoder do not constitute tax returns or portions thereof under section 405(c)(5)(F). The patronage dividends apparently reflect gross income derived by Yoder from selling milk through the cooperatives and, by definition, reflect amounts paid to Yoder by cooperatives on the basis of quantity or value of business done with the cooperatives. I. R. C. § 1388(a); see Treas. Reg. § 1.1388-1(a)(3). Patronage figures do not reflect expenses or losses, thus they fail to establish that Yoder realized *net* self-employment income during each relevant year.[3] Only timely filed income tax returns reporting net self-employment income would provide information relevant to the Social Security Administration in determining whether Yoder has satisfied the requirement of 42 U. S. C. § 416(i)(3)(B) that he have "not less than twenty quarters of coverage during the forty-quarter period" preceding his claim of benefits, a "quarter of coverage" being defined by the Act as "a quarter in which an individual . . . has been credited . . . with $100 or more of [net] self-employment income." 42 U. S. C. § 413(a)(2).

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[2] "Experience gained in the administration of the income-tax law has made it possible to develop adequate methods of meeting problems involved in coverage of the self-employed.

"Reporting. Contributions and benefits would be based on income from self-employment. For both the self-employed person and the Government, the simplest way of reporting such income is as part of the income-tax return.

"Net income from self-employment. Net income from self-employment would be determined entirely on the basis of two figures already included in the income-tax return, namely, income from business or profession (Schedule C) and income from partnerships (Schedule E)."

Proposed Amendments to the Social Security Act: Hearings on H. R. 2893 Before the House Committee on Ways and Means, 81st Cong. 1st Sess. 1081, 1162 (1949) (statement of Dr. Arthur Altmeyer).

[3] I. R. C. § 1402(b) declares the term "'self-employment income' means the net income from self-employment derived by an individual . . . during any taxable year." See also *id.* § 1402(a).

To give effect to the congressional mandate that federal income tax reporting is the only manageable method for accurately ascertaining the income of self-employed claimants in determining eligibility for social security benefits, we hold that Yoder may prove that he had self-employment income during quarters for which the Secretary's records show none only from information filed with timely filed income tax returns.[4] Accord, *Shore v. Califano*, 589 F. 2d 1232, 1239 (3d Cir. 1978); *Singer v. Weinberger*, 513 F. 2d 176, 177 (9th Cir. 1975); *Martlew v. Celebrezze*, 320 F. 2d 887 (5th Cir. 1963).

The order of the district court is reversed with directions to enter an order granting judgment in favor of the Secretary.

REVERSED.

SECTION 210(a)(5) and (6) (42 U.S.C. 410 (a)(5)and (6)) COVERAGE OF WORK FOR U.S. INSTRUMENTALITIES—EMPLOYEES OF NATIONAL BANKS

20 CFR 404.1018 **SSR 82-21a**

The claimant, who was born on July 14, 1917, applied for Old-Age Insurance Benefits (OAIB) in May 1979. The Social Security Administration (SSA) denied her application because she lacked 8 of the 28 quarters of coverage necessary for her to be fully insured as required by law. Although no wages were reported to her earnings record before 1940, the claimant submitted evidence which established that she had worked for two national banks from 1937 through 1939. Based on that employment, the claimant contended that she had acquired at least 8 quarters of coverage and thus was fully insured. *Held*, because national banks are instrumentalities of the United States, services performed in their employ before 1940 were excluded from coverage under section 210 (b) (5) of the Social Security Act of 1935. Consequently, the claimant did not acquire any quarters of coverage before 1940 and thus is not entitled to OAIB because she is not fully insured.

This case came before the Appeals Council under authority of §404.969 of SSA Regulations No. 4, having decided on its own motion to review the hearing decision.

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[4] We recognize that many wage-earners with low incomes may not file income tax returns yet will be credited with payment of social security taxes from the employer's report on W-2 forms timely filed. Such a case is substantially different from the self-employment reports which depend upon a net income basis and require payment with the filed return or by quarterly estimates filed by the taxpayer. For wage-earners the entry on the W-2 form itself evidences the withholding of tax on the total of FICA wages reported and a like payment by the reporting employer.

The general issue before the Appeals Council is whether the claimant is entitled to OAIB. The specific issue is whether the claimant has the 28 quarters of coverage she needs to be fully insured.

The claimant, born on July 14, 1917, filed an application for OAIB on May 15, 1979. SSA determined, initially and upon reconsideration, that the claimant is not entitled to OAIB because she is not fully insured. SSA records indicate that the claimant has 20 of the 28 quarters of coverage she needs to be fully insured.

The claimant's earnings record shows that earnings were first reported to her by National Bank X for the quarter ending March 31, 1940. In connection with her request for a hearing, the claimant alleged that she had also worked for National Bank Y from January 1937 through December 1939. However, no wages were reported by that employer to her earnings record.

At the hearing, the claimant submitted a letter from a bank, dated April 15, 1980, which indicated that it had merged with National Bank Y on April 9, 1955. The records of National Bank Y showed that the claimant was employed by them from December 31, 1934, to May 11, 1937. Further, they indicated she resigned to accept a position with National Bank X.

In view of the above evidence, the administrative law judge (ALJ) held that the claimant had acquired 12 quarters of coverage from 1937 through 1939. Adding those to the 20 quarters of coverage reflected on the earnings record, the ALJ concluded that the claimant has a total of 32 quarters of coverage, is fully insured, and is therefore entitled to OAIB.

Section 202(a) of the Social Security Act provides for the payment of OAIB to an individual who is fully insured, has attained age 62, and has filed an application.

Section 214(a) of the Social Security Act provides, in pertinent part, that a fully insured individual is one who has not less than one quarter of coverage (whenever acquired) for each calendar year elapsing after 1950 and before the year in which he or she attains age 62. Therefore, the claimant needs 28 quarters of coverage to be fully insured.

Section 210(b) of the Social Security Act of 1935 provided, in pertinent part, that "The term 'employment' means any service, of whatever nature, performed within the United States by an employee for his employer, except...(5) Service performed in the employ of the United States Government or of an instrumentality of the United States..."

As amended effective January 1, 1940, section 209(b)(6) of the Act provided, in pertinent part, that service performed in the employ of an instrumentality of the United States was not excepted from coverage unless the instrumentality was (A) wholly owned by the U.S., or (B) exempt from the tax imposed by section 1410 of the Internal Revenue Code (IRC) by virtue of any other provision of law.

The Appeals Council does not agree with the ALJ's decision. Under section 210 (b) (5) of the Social Security Act of 1935, service by an individual in the employ of the U.S. Government or of an instrumentality of the U.S. was excluded from covered employment. National Banks X and Y were instrumentalities of the United States inasmuch as they were "national banks." Accordingly, any earnings the claimant received in their employ before 1940 did not represent creditable wages and did not result in her acquisition of quarters of coverage.

Section 209(b)(6) of the Act, as amended effective January 1, 1940, excluded from coverage, service performed in the employ of an instrumentality of the U.S. which was wholly owned by the U.S. or exempt from the tax imposed by section 1410 of the IRC by virtue of another provision of law. Although national banks are instrumentalities of the U.S., they are neither wholly owned by the U.S. nor exempt from employment taxes under the IRC. National Bank X correctly reported wages paid to the claimant beginning January 1940 because that was the first month the services she performed as their employee constituted "employment" under the Social Security Act.

In view of the above, the Appeals Council finds that the claimant did not acquire any quarters of coverage before 1940 and thus is not entitled to OAIB because she has only 20 of the 28 quarters of coverage she needs to be fully insured.

SECTION 217(a) (42 U.S.C. 417(a)) MILITARY SERVICE WAGE CREDITS—EFFECT OF BENEFIT AWARDED BY ANOTHER FEDERAL AGENCY—WAIVER OF RECOVERY

20 CFR 404.506, 404.507, 404.1342(c), and 404.1363 **SSR 82-22**

The claimant, a Federal Government employee, was born on September 3, 1916, and applied for Old-Age Insurance Benefits (OAIB) in December 1978. His wife and child also applied for benefits on his earnings record. Although the claimant had only 20 of the 27 quarters of coverage he needed to be fully insured, he submitted evidence which showed that he had served in the active military service of the United States (U.S.) from August 12, 1942, through March 26, 1945. The wage credits that were deemed for the claimant's period of military service under section 217 (a) (1) of the Social Security Act (the Act) established the additional quarters of coverage which he needed to be fully insured. Consequently, the claimant, his wife, and his child were awarded benefits effective January 1979. When the claimant subsequently retired from Federal employment, the U.S. Civil Service Commission reported that it had used his period of military service in determining that he was eligible for a civil service annuity effective April 1979. Upon reopening the prior determination, the Social Security Administration (SSA) found that the claimant, his wife, and his child were not entitled to benefits and that they had been overpaid $1,207.90 from April 1979 through October 1979. When SSA notified the claimant of its redetermination, he appealed. *Held*, under section 217 (a) (1) (B) of the Act, wage credits were precluded for the claimant's period of military service because his civil service annuity was based in part on that period. Without those credits, the claimant was not fully insured. Because he had met the eligibility requirements for a civil service annuity in April 1979, the Social Security benefits that were paid on his earnings record from April 1979 through October 1979 constituted an erroneous payment under 20 CFR 404.1363. *Further held*, the claimant was at fault in causing the erroneous payment because the record shows that he understood that an overpayment would occur if his period of military service was used in determining his eligibility for a civil service annuity. Accordingly, recovery of the $1,207.90 overpayment may not be waived.

The general issue is whether the claimant is entitled to quarters of coverage based on his U.S. military service during World War (WW) II. The specific issues are whether the claimant is fully insured for OAIB and whether, he, his wife, and his child were overpaid benefits from April 1979 through October 1979.

The claimant, who was born on September 3, 1916, filed an application for OAIB on December 8, 1978, and stated that he was employed by the U.S. Army Corps of Engineers. When the claimant submitted documentary evidence which showed that he had served in the U.S. Army from August 12, 1942, to March 26, 1945, he was granted deemed wage credits for that period under section 217(a) (1) of the Act. Effective January 1979, an award of monthly benefits was approved to him, his wife, and his child. It is noted that without his military service wage credits, the claimant had only 20 of the 27 quarters of coverage he needed to be fully insured for benefits.

On January 17, 1979, the claimant executed a statement that he understood SSA could grant deemed wage credits for his period of military service in determining his entitlement to, and the amount of, his monthly benefit and that without those credits he may not be insured. He further understood that he would be overpaid if his period of military service was used by the Civil Service Commission in determining his eligibility for a civil service annuity. He agreed to notify SSA immediately if he filed for a civil service annuity.

When the claimant subsequently retired from Federal employment, the U.S. Civil Service Commission reported, on September 13, 1979, that it had used his period of military service in determining that he was eligible for a civil service annuity effective April 1979. Upon reopening the prior determination, SSA found that the claimant, his wife, and his child were not entitled to benefits and that they had been overpaid $1,207.90 from April 1979 through October 1979. When SSA notified the claimant of its redetermination on November 9, 1979, he appealed.

At the hearing, the claimant testified that he had been informed by an SSA district office employee that his period of military service could be used for both civil service annuity and Social Security benefit purposes. He was unable, however, to identify that employee. Because he could not substantiate his allegation, his testimony was not credible.

Section 202(a) of the Act provides, in part, that an individual shall be entitled to OAIB if he or she is fully insured, has attained age 62, and has filed an application.

Section 204(a) of the Act provides, in part, that whenever an incorrect payment has been made, proper adjustment or recovery of the incorrect payment shall be made.

Section 204(b) of the Act and §404.506 of Regulations No. 4 provide that in any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery from, any person who is without fault if such adjustment or recovery would defeat the purpose of title II of the Act or would be against equity and good conscience.

Section 213(a)(2)(A) of the Act defines the term "quarter of coverage", and section 214(a) of the Act explains how many quarters of coverage a person needs to be a "fully insured individual."

Section 217 of the Act provides, in pertinent part:

> "(a) 1) For purposes of determining entitlement to and the amount of any monthly benefit for any month after August 1950...payable under this title on the basis of the wages and self-employment income of any World War II veteran...such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of $160 in each month during any part of which he served in the active military or naval service of the United States during World War II. This subsection shall not be applicable...if
>
> > ...(B) a benefit...which is based, in whole or in part, upon the active military or naval service of such veteran during World War II is determined by any agency...(other than the Veteran's Administration) to be payable by it under any other law of the United States or under a system established by such agency...."

Section 404.507 of Regulations No. 4 provides, in pertinent part, that—"What constitutes fault...on the part of the overpaid individual...depends upon whether the facts show that the incorrect payment to the individual...resulted from:

> (a) An incorrect statement made by the individual which he knew or should have known to be incorrect; or
>
> (b) Failure to furnish information which he knew or should have known to be material; or
>
> (c) With respect to the overpaid individual only, acceptance of a payment which he either knew or could have been expected to know was incorrect."

Section 404.1363 of Regulations No. 4 provides, in pertinent part, that—

> "If...we receive notice from another Federal agency...(other than the Veterans Administration) that a Federal benefit is payable to you by that agency...based on the veteran's World War II...active service, our payments to you are erroneous to the extent the payments are based on the World War II...wage credits. The payments are erroneous beginning with the first month you are eligible for the Federal benefit."

Under section 217(a)(1)(B) of the Act, wage credits were precluded for the claimant's period of military service because his civil service annuity was based in part on that period. Without those credits, the claimant was not insured. Because he had met the eligibility requirements for a civil service annuity in April 1979, the Social Security benefits that were paid on his earnings record from April 1979 through October 1979 constituted an erroneous payment under §404.1363 of Regulations No. 4.

In light of his statement of January 17, 1979, it is clear that the claimant understood that his period of military service could not be used for both civil service annuity and Social Security benefit purposes. He also understood that if he was awarded Social Security benefits and later applied for a civil service annuity, he would be overpaid Social Security benefits if his period of military service was used in determining his eligibility for that annuity. He also had agreed to notify SSA when, and if, he did file for a civil service annuity. Because the claimant knew that credit for his military service could not be used in determining his entitlement to OAIB, he was at fault in causing the overpayment from April 1979 through October 1979. Consequently, recovery of the $1,207.90 overpayment may not be waived.

SECTIONS 1602 and 1612(a) (42 U.S.C. 1381a and 1382a(a)) SUPPLEMENTAL SECURITY INCOME—UNEARNED INCOME—DISABILITY BENEFITS

20 CFR 416.1102 and 416.1121(a) **SSR 82-23**

The claimant applied for Supplemental Security Income (SSI) benefits as a disabled individual. His disability resulted from an accident, which occurred on June 19, 1980. The claimant has received $95.00 per week in disability benefits from an insurance company since the date of the accident. When the Social Security Administration (SSA) determined that the claimant was ineligible for SSI benefits because his income exceeded the statutory limit, he appealed. The claimant alleged that he had filed a third party action against the person he claims was responsible for his accident. If the claimant is successful in his lawsuit, the insurance company, which has filed a lien under applicable State law against the proceeds of any recovery from a third party by the claimant, will be entitled to recover the full amount of the disability benefits that it has paid to the claimant. Because of the lien, the claimant contended that the weekly payments made to him by the insurance company constituted a loan and thus should not be considered income for SSI benefit purposes. *Held*, the payments made to the claimant by the insurance company did not constitute a loan because, under section 1612(a)(2)(B) of the Social Security Act (the Act) and 20 CFR 416.1121(a), those payments were considered unearned income. Consequently, the claimant was ineligible for SSI benefits because his income exceeded the statutory limit.

The general issue is whether the claimant was eligible for SSI benefits as defined in the Act. The specific issue is whether the disability payments made by an insurance company can be considered a loan or must be counted as unearned income under title XVI of the Act.

The claimant, who became disabled on June 19, 1980, as a result of an accident, applied for and was determined to be entitled to a period of disability and Disability Insurance Benefits. He was also found to be disabled for SSI purposes.

The claimant has been receiving $95.00 per week in disability benefits from an insurance company since his accident. The insurance company has filed a lien, pursuant to Section 277 of the New York State Insurance law, against the proceeds of any recovery from a third party by the claimant. The claimant and his attorney have stipulated that they have filed a third party action against the person they claim was responsible for the claimant's accident. In the event that the claimant is successful in this lawsuit, the insurance company will be entitled to recover the full amount of the disability benefits that is has paid to the claimant.

The claimant and his attorney both contended that the weekly disability benefits paid to the claimant constituted a loan because of the lien. If the claimant is awarded money damages, the insurance company will be paid the amount of its lien. Therefore, it is the claimant's contention that since his disability benefits are subject to repayment if his lawsuit is successful those benefits should not be considered income and thus he should be eligible for SSI benefits.

Section 1602 of the Act provides that each aged, blind, or disabled individual who is determined to be eligible on the basis of income and resources shall be considered an eligible individual for SSI benefits under title XVI of the Act.

Section 1612(a) of the Act provides that income means both earned income and unearned income.

Section 1612 (a) (2) (B) of the Act provides that unearned income includes any payments received as an annuity, pension, retirement, or disability benefit, including veterans' compensation and pensions, workmen's compensation payments, old-age, survivors, and disability insurance benefits, railroad retirement annuities and pension, and unemployment insurance benefits.

Section 416.1102 of Regulations No. 16 provides that income is anything a person receives in cash or in kind that a person can use to meet his or her needs for food, clothing, or shelter. In-kind income is not cash, but is actually food, clothing, or shelter, or something a person can use to get one of these.

Section 416.1121(a) of Regulations No. 16 provides that some types of unearned income are annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, Social Security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities, and unemployment insurance benefits.

The law and regulations are quite clear and precise in providing that any disability benefits paid to a claimant are considered unearned income, and if total countable income (including disability benefits) exceeds the amount stated in the law, the claimant is ineligible for SSI benefits. Therefore, SSA concluded that the payments made by the insurance company to the claimant did not constitute a loan, but were disability benefits, even though the insurance carrier has a lien against the proceeds of any recovery from a third party by the claimant. Consequently, the disability benefits that were paid to the claimant must be counted as unearned income for SSI benefit purposes. Accordingly, SSA concluded that the claimant was not eligible for SSI benefits because his income exceeded the statutory limit.

SECTION 1611(a)(1) (42 U.S.C. 1382(a)(1)) SUPPLEMENTAL SECURITY INCOME—ELIGIBILITY—LOSS OF ESSENTIAL PERSON STATUS

20 CFR 416.241, 416.242, 416.243, and 416.248 **SSR 82-24**

> Because the claimant's mother met the definition of an essential person living in the claimant's home, the claimant qualified for an essential person increment. When the mother later became eligible for SSI benefits, the Social Security Administration (SSA) informed the claimant that the essential person increment was no longer applicable in determining the amount of her SSI benefit. Consequently, the claimant appealed. *Held*, under 20 CFR 416.248(d), the claimant's mother lost her status as an essential person when she became eligible for SSI benefits in her own right; therefore, the claimant no longer qualifies for the essential person increment provided in 20 CFR 416.241.

The general issue is whether the claimant is subject to a reduction in benefits under title XVI of the Social Security Act. The specific issue is whether removal of the claimant's essential person increment is correct because the individual who was her essential person is now eligible for SSI benefits in her own right.

The claimant protested the determination made reducing her SSI benefits and requested a hearing. She is currently a recipient of SSI benefits and suffers from schizophrenia. When the claimant was converted from the State Public Assistance Program to the Federal Supplemental Security Income Program, the Federal Government determined that her mother was a person whose needs would be taken into account in determining the needs of the claimant. It was also determined that the mother lived with the claimant, was not receiving SSI benefits, was not an eligible spouse, and did not have income or resources in an amount that would cause the claimant to lose her benefits. Therefore, the claimant's mother met the definition of an essential person under 20 CFR 416.243.

Subsequently, the mother began receiving SSI benefits and thus lost her status as an essential person. (See 20 CFR 416.248(d).) At the hearing, both the claimant and her mother conceded that the mother was receiving SSI benefits, but they requested that the benefits not be reduced because they would not have enough money to live on.

Section 416.241 of Regulations No. 16 provides that—"In determining (for purposes of this part) the eligibility for and the amount of the supplemental security income benefit payable to any qualified individual (as defined in §416.242) with respect to any period for which such individual has in his home an essential person (as defined in §416.243), the standard payment amount as prescribed in section 1611 of the Act shall be increased if consideration of the income and resources of such essential person would not cause the qualified individual to lose eligibility for such benefits. In determining whether the qualified individual loses eligibility on the basis of the income of the essential person, the standard of payment against which such income will be applied is that prescribed in section 1611(a) of the Act plus the essential person increment(s). The resource limitation in §416.1205 (as modified by §416.1260, where applicable) will apply."

Section 416.242 of Regulations No. 16 provides that—"For purposes of §416.241, a qualified individual is any individual who for the month of December 1973 was a recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI of the Social Security Act, and, in determining the need of such individual for aid or assistance for December 1973 under such State plan, there were taken into account the needs of a person other than the qualified individual (i.e., an 'essential person') who:

(a) Was living in the home of the qualified individual; and
(b) Was not eligible in his or her own right for aid or assistance under such State plan for December 1973."

Section 416.243 of Regulations No. 16 provides that—"An essential person is any person who for the month of December 1973 was a person whose needs were taken into account in determining the need of a qualified individual (see §416.242) for aid or assistance under a State plan approved under title I, X, XIV, or XVI of the Social Security Act, as in effect for June 1973, and who:

(a) Lives in the home of the qualified individual; and
(b) Is not eligible in his or her own right for supplemental security income benefits and;
(c) Is not an eligible spouse (as defined in section 1614(b) of the Act) of the qualified individual or any other individual; and
(d) Does not have income or resources in an amount that will cause the qualified individual to lose eligibility for benefits (see §416.1190 and §416.1203)."

Section 416.248 of Regulations No. 16 provides, in pertinent part, that—"(a)...If for any month after December 1973, any essential person fails to meet the criteria specified in §416.243, such person shall not thereafter be considered to be an essential person....(d)...If the essential person becomes eligible for supplemental security income payments on the basis of age, blindness, or disability (see §416.201), his status as an essential person shall continue throughout the month prior to the month for which he is determined to be eligible for such payment in his own right and shall cease at the end of such prior month."

Under §416.248(d) of Regulations No. 16, the claimant's mother lost her status as an essential person when she became eligible for SSI benefits in her own right. Consequently, the claimant no longer qualifies for the essential person increment provided in §416.241 of Regulations No 16 and thus SSA's determination reducing her SSI benefit is affirmed.

SECTIONS 1611(a)(1)(A) and 1614(f)(2) (42 U.S.C. 1382(a)(1)(A) and 1382c(f)(2)) SUPPLEMENTAL SECURITY INCOME—ELIGIBILITY—EXCESS INCOME—DEEMING OF INCOME FROM A STEPPARENT

20 CFR 416.1185(b)* **SSR 82-25c**

Hammond v. Secy, HEW, 10th Circuit, CIV. NO. 79-2123 (04/21/81)

The claimants, who are siblings and minors, were receiving Supplemental Security Income (SSI) benefits as disabled individuals. Since the date of their mother's marriage, the claimants have lived in the same household with her and their stepfather. Under 42 U.S.C. 1382c(f)(2), the income of a child is deemed to include the income of a parent, or stepparent, who lives in the same household as the child, regardless of whether the income of the parent, or stepparent, is actually available to the child, "except to the extent determined by the Secretary to be inequitable under the circumstances." Accordingly, the claimants' income was deemed to include the income of their stepfather. When the Social Security Administration (SSA) determined that the claimants were no longer eligible for SSI benefits because their income exceeded the allowable amount, the claimants' mother appealed. Counsel for the claimants argued that the statutory language quoted above requires that in each case SSA must make a factual determination of whether the income of a parent, or stepparent, is actually available to the child before the income can be deemed to the child. The district court's remand of the case to SSA to determine whether the stepfather's income was actually available to the claimants was reversed by the Court of Appeals. In affirming SSA's determination, the Court of Appeals found that to interpret the statutory language quoted above as meaning that the income of a stepparent is deemed to a stepchild only if the income is actually available to the stepchild would render meaningless the prior statutory language that the income is deemed income of the child "whether or not available to such individual." Consequently, the Court of Appeals *held* (1) that the "except" language in the statute cannot be read to excise from the statute the prior clause which provides that the income of the parent, or stepparent, is deemed to the child "whether or not available" and (2) that practical effect has been given to the "excepting" language in the statute by the implementing regulation excluding certain items in determining the income of the parent or stepparent.

MC WILLIAMS, Circuit Judge:

This case concerns the termination of benefits under the Supplemental Security Income (SSI) Program, which program is provided for by the Social Security Act. The Secretary of the Department of Health, Education and Welfare[1] terminated the benefits of William H. Ross and Richard R. Ross, minor sons of Billie Jean Hammond, on the ground that the two children no longer were eligible for benefits because their stepfather's income, which the Secretary deemed, under the applicable statute, was attributable to the children, was higher than allowed for SSI recipients.[2]

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*The regulations used to determine income under title XVI of the Social Security Act were recodified effective October 2, 1980. See 45 FR 65541-65559 (1980) (recodified in 20 CFR 416.1100-416.1182). The provisions of the regulation cited in this Ruling have been rewritten as part of the recodification, but not substantively changed, and now appear in §416.1160(a)(2) and §416.1165.

[1] The Department of Health, Education and Welfare (HEW) is now the Department of Health and Human Services (HHS).

Mrs. Hammond, as the representative of her two minor sons, William and Richard, sought judicial review of the Secretary's termination order. The District Court, on review, remanded the case to the Secretary with the direction that he make a determination as to whether the income of the stepfather is, in fact, "available" to William and Richard Ross. Implicit in the remand order was the further direction that if the income of the stepfather is *not* "available" to William and Richard Ross, then the Secretary should hold that they are eligible for benefits and resume benefit payments. The District Court's order appears as Hammond v. Secretary of Health, Education and Welfare, 475 F. Supp. 675 (D. Colo. 1979). The Secretary now appeals from that order.

This case turns on the meaning of a statute and an agency regulation implementing the statute. The regulation provides as follows:

> In the case of an individual who is a child (as defined in § 416.1050) and under age 21, such child's income shall, subject to the succeeding sentences of this paragraph and to paragraph (c) of this section, be deemed to include (except as otherwise provided in this section), any income (as defined in § 416.1102(a)) of a parent of such individual (or the spouse of such a parent) who is not eligible for benefits under this part and is living in the same household as the child whether or not such income is available to the child. 20 C.F.R. § 416.1185(b) (1980) (emphasis added).

The statute involved reads as follows:

> For purposes of determining eligibility for and the amount of benefits for any individual who is a child under age 21, such individual's income and resources shall be deemed to include any income and resources of a parent of such individual (or the spouse of such a parent) who is living in the same household as such individual, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances. 42 U.S.C. § 1382c(f)(2) (1976) (emphasis added).

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[2] The SSI program provides benefits for disabled, elderly, and blind individuals who have income and other resources below certain levels. In addition, the states are encouraged to provide supplemental aid, with the federal government absorbing state administrative costs under a plan allowing states to distribute assistance through the federal government.

The two boys who challenge the termination of their benefits in this case were eligible for assistance under 1972 amendments to the Social Security Act. These amendments provided for the first time that disabled minors could qualify for aid under the SSI program, which is administered by HHS.

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As above mentioned, this appeal concerns only the interpretation and meaning to be given a statute, and an agency regulation implementing that statute. The constitutionality of neither the statute nor the regulation is raised. Both the statute and the regulation clearly state that, in the case of a disabled individual under 21 years of age, the income of the child's parent, or the spouse of such a parent, who lives in the same household as the disabled child, is deemed to be income of the disabled child, regardless of whether such income is "available" to the disabled minor. As indicated, the mother of the disabled children, William and Richard Ross, has now married Sylvester Hammond, and the Ross children live in the same household as Mr. and Mrs. Hammond. Such being the case, under the applicable statute and regulation, the Secretary determined that Mr. Hammond's income was deemed to be income of the Ross children, whether or not the income was, in fact, "available" to them.

In this Court, counsel for the Ross children concedes that but for the last clause of section 1382c(f)(2), he would have no case. As has been indicated, section 1382c(f)(2) provides, in essence, that income of a disabled child is deemed to include the income of a parent, or stepparent who lives in the same household as the disabled child, whether or not such income is available to the child, "except to the extent determined by the Secretary to be inequitable under the circumstances." Counsel argues that the statutory language just quoted requires that in each case the Secretary must make a factual determination of whether the income of the parent, or stepparent, is actually available to the disabled child before such income can be deemed income of the child. The District Court obviously agreed with counsel, since the case was remanded to the Secretary with direction to ascertain whether the stepfather's income was in fact available to the Ross children. And the further thrust of the remand is that, if such income is not available,[3] then it will not be chargeable to the Ross children. We do not agree with this interpretation.

As mentioned above, the statute clearly states that income of a disabled child is deemed to include income of a parent, or stepparent, who lives in the same household as the disabled child, regardless of whether the income of the parent, or stepparent, is actually available to the disabled child. To interpret the statutory language "except to the extent determined by the Secretary to be inequitable under the circumstances" as meaning that income of a stepparent is chargeable to the disabled child *only* if such income is actually available to the stepchild would render meaningless the prior statutory language that such income is deemed income of the child "whether or not available to such individual." The "except" language in the statute undoubtedly has a meaning of its own, but it cannot be read to excise from the statute the prior clause providing that income of the parent, or stepparent, is chargeable to the child "whether or not available." To interpret the statute in the manner suggested by counsel would require this Court to give a meaning to statutory language that is at least somewhat nebulous in nature which would totally negate other statutory language which is crystal clear in its meaning. This we decline to do.

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[3] The court below relied, in large part, on a line of cases dealing with the Aid to Families With Dependent Children (AFDC) program, which also is administered by HHS. The District Court applied the "actually available" rule, holding that the AFDC cases "stand for the proposition that income of a legally non-responsible person must be actually available to a child welfare recipient in order for it to be counted against his eligibility or level of benefits." 475 F. Supp. at 677 (citing Van Lare v. Hurley, 421 U.S. 338 (1975); Lewis v. Martin, 397 U.S. 552 (1970), and King v. Smith, 392 U.S. 309 (1968)). All three of the cited cases, however, involved state schemes for administering AFDC benefits which conflicted with the provisions of the Social Security Act setting up the federally funded AFDC program. For a summary of the holdings in the three cases, see *Van Lare*, 421 U.S. at 344-48.

In the case at bar, unlike the AFDC cases, there is no conflict between federal and state laws, since only the federal scheme for administering benefits is challenged. Furthermore, the holding of the AFDC cases cannot be construed to be so broad as to require that an "actually available" rule be applied to every federal welfare benefits program.

It should be noted that not *all* income of the parent or stepparent is necessarily attributed to the child. In our view, the Secretary, by regulation, has given practical effect to the "excepting" language in the statute by excluding certain items in determining the income of the parent or stepparent.[4]

A case quite similar to the present one is *Kollett v. Harris*, 619 F.2d 134 (1st Cir. 1980), which was announced subsequent to the District Court's judgment in the instant case. In *Kollett*, the First Circuit upheld the constitutionality of section 1382c(f)(2)[5] and the implementing regulation, and, in effect, construed the statute in the same manner as have we. In so doing, the First Circuit specifically disagreed with the holding of the trial court in the instant case, making the following comment:

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[4] The formula which the agency uses to determine the portion of the parent's and stepparent's incomes that are attributed to the child for the purposes of determining both eligibility and the amount of benefits involves four steps, set out in the paragraphs that follow:

(1) The income(s) of any parent and any stepparent living in the same household with the disabled child is the starting point.

(2) Certain items are subtracted as exclusions under 40 C.F.R. § 416.1185(d) (1980). These include other welfare assistance, scholarships, the value of food stamps, and any income used to comply with the terms of court-ordered support for other persons, such as children by a former marriage.

(3) A living allocation is subtracted for each child living in the same household and not eligible for SSI benefits.

(4) An allocation is deducted for living and work expenses of the parent and stepparent living in the same household with the disabled child. The amount of this allocation depends, in part, on whether the income of the parent is "earned" or "unearned," as defined by the agency's regulations. The purpose of the allowance apparently is to encourage welfare benefits recipients to work.

> We disagree with *Hammond v. Secretary of HEW*, 475 F.Supp. 675 (D. Colo. 1979), which read the statutory words "determine," "inequitable," and "circumstances" to "imply a factual determination on an individual basis" not satisfied "by the perfunctory application of a set of regulations to a claim." *Id.*, 678. Accordingly, the court ordered that the plaintiff, a stepchild, be given an opportunity to demonstrate his stepfather did not contribute to his support. Individualized hearing would require that the very problem Congress sought to avoid—proving whether a stepparent living in the same household actually contributed to the child's support—be confronted. Individualized determinations are not a constitutional requisite when, as here, "Congress can rationally conclude not only that generalized rules are appropriate to its purposes and concerns, but also that the difficulties of individual determinations outweigh the marginal increments in the precise effectuation of congressional concern which they might be expected to produce." *Weinberger v. Salfi*, 422 U.S. 749, 785, 95 S.Ct. 2457, 2476, 45 L.Ed.2d 522 (1975).

619 F. 2d at 139 n. 4.

The First Circuit in *Kollett* also made the following comment which has present pertinency:

> We have already concluded that neither the statute nor the deeming regulation is unconstitutional insofar as the income of a parent or stepparent living in the same household as a disabled child is deemed to that child, thus reducing or eliminating the child's benefits, even though the income may not in some cases be actually available to the child . . . . Especially in light of this, the Secretary's construction of 42 U.S.C.

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[5] Unlike the situation here, *Kollett* and other cases involving federal welfare benefits have involved, in addition to issues of statutory interpretation, constitutional challenges to the schemes for distributing benefits. For the most part, courts have been reluctant to find that methods of administering welfare benefits programs are unconstitutional. One such case which was relied upon by the lower court in the present case was a District Court decision which subsequently was reversed on the constitutional grounds by the Second Circuit. Termini v. Califano, 611 F.2d 367 (2d Cir.), *reversing* 464 F. Supp. 797 (W.D.N.Y. 1979). In *Termini*, the District Court held that it was irrational for the government to provide two levels of SSI benefits, one for individuals living alone and another for those living with others. 611 F.2d at 369. In reversing the District Court, the Circuit applied the rational basis test, 611 F.2d at 639, holding that "the rational basis is supplied by the commonsense proposition that individuals living with others usually have reduced per capita costs because many of their expenses are shared." 611 F.2d at 370.

See also Weinberger v. Salfi, 422 U.S. 749, 777-85 (1975) and Flemming v. Nestor, 363 U.S. 603, 611, *rehearing denied*, 364 U.S. 854 (1960).

> § 1382c(f)(2) cannot be held erroneous. The Secretary declined to create a blanket exclusion from deeming for all income that might be unavailable income; instead, the Secretary singled out certain types of fairly clear unavailability for exceptions (e.g., income needed to meet the minimum living expenses of parents and siblings), but not others (e.g., income legally—but not, necessarily, in fact—unavailable to the child because the stepparent has no legal duty of support). Rejection of the blanket approach is consistent with the statutory language. The phrasing of 42 U.S.C. § 1382c(f)(2) indicates that Congress anticipated the eventuality that the income and resources of a parent or stepparent might not, for one reason or another, actually be available to the disabled child, but provided, nonetheless, that deeming occur despite unavailability "except to the extent determined by the Secretary to be inequitable under the circumstances." The statutory language indicates that whether or not parental or stepparental income was available to the child, its exclusion was to be the exception, not the rule, and was to be justified, if at all, only by the Secretary's affirmative determination of inequity. 619 F.2d at 141.

Judgment reversed and case remanded with direction to the trial court to affirm the Secretary's decision and to dismiss the complaint and action.

SECTIONS 1611(a)(1)(B)(i) and 1613(a) (42 U.S.C. 1382(a)(1)(B)(i) and 1382b(a)) SUPPLEMENTAL SECURITY INCOME—RESOURCES—REAL PROPERTY

20 CFR 416.1201, 416.1205(a), 416.1210(a), and 416.1212 SSR 82-26

The claimant applied for Supplemental Security Income (SSI) benefits as a disabled individual in September 1980. Although the claimant and his wife, who is ineligible for SSI benefits, live together in a rented house, they also own a parcel of land with a two room structure and a travel trailer on it in another State. The claimant and his wife plan to use that property as their residence for approximately half of the year at some time in the future. At the present time, however, they only use it as a vacation home for approximately one month each year. When the equity value of the claimant's property was considered along with his other nonexcludable resources, including savings and checking accounts, the claimant's resources exceeded the statutory limit; consequently, the Social Security Administration (SSA) denied his application. The claimant appealed, however, contending that because the property was the only real property he owned it should be considered his home for SSI eligibility purposes and excluded from consideration as a resource under 20 CFR 416.1212(a)(2). *Held*, the claimant's property was not excludable from resources as a home because, under 20 CFR 416.1212(b), it was not his principal place of residence. Accordingly, since the equity value of that property had to be included in determining his countable resources, the claimant was ineligible for SSI benefits because his resources exceeded the statutory limit.

The issue is whether certain real property owned by the claimant is excludable as a home in determining his countable resources for SSI eligibility purposes.

The claimant is a 49-year-old married individual who filed an application for SSI benefits due to disability on September 4, 1980. At the time of his application for title XVI benefits, the claimant reported that he was residing in a rented house with his wife, who is ineligible for SSI benefits and employed by a local school district.

The claimant also disclosed that he and his wife own a half acre parcel of land with a two room structure and a travel trailer on it in another State. Although the claimant and his wife look forward to eventually using that property as their residence during approximately half of the year, currently they only use it as a vacation home during approximately one month of each year. When SSA determined that the claimant's real property was a countable resource and denied his application because his total countable resources exceeded the statutory limit, the claimant filed an appeal. Since the claimant's property is the only real property which he and his wife own, he believes that it should be considered his home for SSI eligibility purposes and excluded from consideration as a resource.

Section 1611(a)(1)(B)(i) of the Social Security Act and §416.1205(a) of Regulations No. 16 provide that an aged, blind, or disabled individual who is living with an ineligible spouse shall be eligible for benefits under title XVI of the Act if his nonexcludable resources do not exceed $2,250.00 and all other eligibility requirements are met.

Section 1613(a) of the Act provides that certain items shall be excluded in determining the resources of an individual.

Section 416.1201 of Regulations No. 16 defines resources as "cash or other liquid assets or any real or personal property that an individual...owns and could convert to cash to be used for his support and maintenance. If the individual has the right, authority or power to liquidate the property, or his share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual...

> (c) Nonliquid resources include all other properties. The term includes both real and personal property. Nonliquid resources are evaluated according to their equity value except as otherwise provided....
>
> (2) ...the 'equity value' of an item is defined as: ...The price that item can reasonably be expected to sell for on the open market in the particular geographic area involved; minus . . . Any encumbrances."

Section 416.1210 of Regulations No. 16 provides, in pertinent part, that—

> "In determining the resources of an individual (and spouse, if any) the following items shall be excluded:
>
> (a) The home (including the land appertaining thereto) to the extent its value does not exceed the amount set forth in §416.1212...."

Section 416.1212(a) (2) of Regulations No. 16 provides that—

> "Effective October 1976, the entire value of a home is excluded in determining the resources of an individual (and spouse, if any)."

Section 416.1212(b) of Regulations No. 16 provides that—

> "A home...is any shelter in which the individual (and spouse, if any) has ownership interest and which is used by the individual (and spouse, if any) as his principal place of residence. The home includes any land that appertains thereto and any related outbuildings necessary to the operation of the home."

Title XVI of the Act provides certain eligibility requirements that an individual must satisfy to receive SSI benefits. One of those requirements is a limit on the amount of resources that an individual can retain and still receive SSI benefits. The Act prescribes that the total resources for an individual who is living with an ineligible spouse must not exceed $2,250. In determining the value of resources that count against the limitation, certain items owned by an individual are excluded from consideration. Among the items excluded from the resource limitation is an individual's home. The regulations define a home for purposes of a resource exclusion as any shelter in which the individual has an ownership interest and which is used by the individual as his or her principal place of residence. Only the principal place of residence may be an excludable home for title XVI purposes. If an individual owns property or a residence which is not the individual's principal place of residence, the value of the property or residence must be included in computing the value of the individual's countable resources.

Under the circumstances present in this case, the weight of the substantial and credible evidence confirms that the claimant's real property is not excludable from resources for purposes of determining his eligibility for SSI benefits. While the property may represent the only real property in which the claimant and his wife have an ownership interest, the claimant's principal place of residence appears very clearly from the record to be the house that he and his wife rent. They have rented their current residence for a period of over two years, and the claimant's wife is regularly employed by the school district in that area. When he applied for SSI benefits, the claimant characterized the property he owned as a vacation residence at which he and his wife typically spent no more than one month out of each year.

Although the claimant's property is valued at $2,500, encumbrances total $275; therefore, under 20 CFR 416.1201(c)(2) of Regulations No. 16, the equity value of that property is $2,225. When the equity value of the claimant's property is considered along with his other nonexcludable resources, including savings and checking accounts, the claimant's resources exceed the $2,250 resource limitation. Accordingly, the claimant is ineligible for SSI benefits because his countable resources exceed the statutory limit.

SECTION 1612(a)(2)(F) (42 U.S.C. 1382a(a)(2)(F)) SUPPLEMENTAL SECURITY INCOME—UNEARNED INCOME—GRAZING FEES

20 CFR 416.1103(c), 416.1121(c), and 416.1234 **SSR 82-27a**

R, a recipient of Supplemental Security Income (SSI) benefits as a member of an eligible couple, is of Indian descent and the beneficial owner of certain real property, on which neither she nor her husband resides, that is located within an Indian reservation. Although R cannot sell her interest in the property without the approval of the Bureau of Indian Affairs, she does receive grazing fees from ranchers who graze their cattle on her land. R contends that the grazing fees do not constitute countable income for SSI benefit purposes. Instead, she contends, that the grazing fees constitute the conversion of a resource from one form to another within the meaning of 20 CFR 416.1103(c) and as such, are excludable as a resource under 20 CFR 416.1234. *Held*, the grazing fees do not constitute a resource or the conversion of a resource within the meaning of 20 CFR 416.1103(c); instead, the fees constitute rental income, as defined in 20 CFR 416.1121(d), because they are paid for the use of real property. Consequently, the grazing fees constitute unearned income for SSI benefit purposes.

The issue before the Appeals Council is whether the grazing fees received by the claimants constitute "income" or "resources," and whether such fees may be excluded from consideration in determining their eligibility for SSI benefits.

R and her husband, an eligible couple, first became eligible for SSI benefits effective February 1974, based upon an application filed on February 22, 1974. Both claimants are presently entitled to benefits payable under title II of the Social Security Act (the Act).

R is of Indian descent and the beneficial owner of certain real property located within an Indian reservation. She has complete ownership of one allotment of land and fractional interests in several other allotments, her interests ranging from approximately 2 to 11 percent. Neither R nor her husband resides on the property, but they permit ranchers to graze cattle on the land in return for grazing fees. R cannot sell any interest she holds in the property without the approval of the Bureau of Indian Affairs, as the property consists entirely of trust lands.

Ordinarily, non-home real property is considered a "resource," within the meaning of §416.1201 of Regulations No. 16, and as such, would be counted towards the resource limitation of $2,250 contained in section 1611(a)(2)(B) of the Act. However, inasmuch as R cannot dispose of her interest in the property without the consent of the Bureau of Indian Affairs, the property is excluded from consideration as a "resource," pursuant to §416.1234 of Regulations No. 16. R contends that grazing fees received for use of the restricted land constitute the conversion of a resource within the meaning of §416.1103(c) of Regulations No. 16. Because the resource converted to yield the fees is excluded under §416.1234 of Regulations No. 16, R asserts that the fees are also an excludable resource.

Section 416.1102 of Regulations No. 16 provides, in pertinent part, that—

> "Income is anything you receive in cash or in kind that you can use to meet your needs for food, clothing, or shelter . . . ."

Section 416.1103 of Regulations No. 16 provides, in pertinent part, that—

> "...what you receive from the sale or exchange of your own property is not income; it remains a resource...(c)...Receipts from the sale, exchange, or replacement of a resource are not income but are resources that have changed their form...."

Section 416.1104 of Regulations No. 16 provides that "There are different types of income, earned and unearned." Earned income is defined in §416.1110 of Regulations No. 16 as "what you receive as wages or as net earnings from self-employment." Unearned income is defined in §416.1120 as "all income that is not earned income."

Section 416.1121 of Regulations No. 16 provides, in pertinent part, that "rents" constitute unearned income. Paragraph (d) of that section of the regulations defines "rents" as "payments you receive for the use of real or personal property such as land, housing, or machinery."

Section 416.1201 of Regulations No. 16 provides, in pertinent part, that—

> "...resources mean cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns

> and could convert to cash to be used for his support and maintenance. If the individual has the right, authority or power to liquidate the property, or his share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).
>
> ...Liquid resources are those assets that are in cash or are financial instruments which are convertible to cash.
>
> ...Nonliquid resources include all other properties. The term includes both real and personal property...."

Section 416.1234 of Regulations No. 16 provides that—

> "In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, there shall be excluded such restricted, allotted lands as such individual (and spouse, if any) may possess if such individual (and spouse, if any) cannot sell, transfer or otherwise dispose of such land without permission of other individuals, his tribe or an agency of the Federal Government."

In considering this case, the Appeals Council is guided by the obvious intent of §416.1103(c) of Regulations No. 16 that a resource not be counted differently simply by virtue of its having been changed to a different form, e.g., cash, where the total assets available to the claimant have remained the same. For example, the sale of a piece of equipment is a change of form (conversion), but does not result in increased assets. After the sale, the seller has cash instead of the resource. Here, however, because the land remains intact after grazing, the seller has both the cash and the land. Viewed in this light, the grazing fees cannot be considered a "sale or exchange" of a resource, and must be considered "unearned income." The Appeals Council believes that the grazing fees received by R represent rental income within the meaning of §416.1121(d) of Regulations No. 16, as the fees are paid for the use of real property.

SECTION 1614(f)(1) (42 U.S.C. 1382c(f)(1)) SUPPLEMENTAL SECURITY INCOME—DEEMING OF INCOME FROM INELIGIBLE SPOUSE—ALLOCATIONS FOR INELIGIBLE CHILDREN—"INELIGIBLE CHILD" DEFINED

20 CFR 416.1160(c) and 416.1163 **SSR 82-28a**

The claimant, who lives in the same household with her husband and their three grandchildren, applied for Supplemental Security Income (SSI) benefits as a disabled individual in November 1978. Her husband is employed, and neither he nor their grandchildren are eligible for SSI benefits. When the Social Security Administration (SSA) determined that the claimant was ineligible for SSI benefits because the income deemed to her from her husband exceeded the statutory limit, she appealed. Under 20 CFR 416.1163(b), an allocation for "ineligible children" in the household is applicable before an individual's income is deemed to include the income of his or her spouse. The administrative law judge (ALJ) found that this allocation was applicable for the claimant's grandchildren. In granting the allocation, the ALJ reasoned that the term "ineligible child" was defined by age, rather than by age and relationship, and that, under section 1614 (f) (1) of the Social Security Act (the Act), it would be inequitable to deny the allocation because the grandchildren were dependent upon the claimant's husband for support. The Appeals Council found that the term "ineligible child," as defined in 20 CFR 416.1160(c), applies only to the claimant's natural or adopted child or to a child of the claimant's spouse. The Council further found that Congress did not intend the specific amount of deemed income to be determined by the equities of each individual case because a broad standard would be impossible to administer in an effective manner. Therefore, the Appeals Council *held* that the allocation provided in 20 CFR 416.1163(b) was inapplicable for the claimant's grandchildren. Consequently, the claimant was ineligible for SSI benefits because her countable income exceeded the statutory limit.

The general issue before the Appeals Council is whether the claimant is eligible for SSI benefits. This depends upon whether her countable income exceeds the statutory limit. Specifically at issue is whether the amount of income deemed to the claimant from her husband, who lives with her and is ineligible for SSI benefits, may be reduced by an "allocation" for their three grandchildren, who are under age 18, are ineligible for SSI benefits, and live in their household. Whether an allocation may be made for the grandchildren depends on the definition of the term "ineligible child."

The claimant, born on December 17, 1926, filed an application for SSI benefits on November 22, 1978. The claimant was found to be disabled in a prior hearing decision issued on September 27, 1979. The case was then referred to SSA for a determination as to whether the claimant met the nondisability requirements for eligibility. It was determined initially and upon reconsideration that the income deemed to the claimant from her husband was in excess of the statutory limit and thus precluded her eligibility for SSI benefits. In determining the amount of income deemed to the claimant, her husband's income was not reduced by an allocation for the grandchildren living in their household because they were not her natural or adopted children or the natural or adopted children of her husband.

In his decision, the ALJ found, however, that an allocation could be made for the claimant's grandchildren. In reaching this conclusion, the

ALJ reasoned that the term "ineligible child" was defined by age, rather than by age and relationship. The ALJ further found that even if the claimant's grandchildren were not considered "ineligible children" for deeming purposes by SSA, it would be inequitable not to allow an allocation for them as they were essentially dependent upon the claimant's husband for support. He cited section 1614 (f) (1) of the Act which provides that all income and resources of an individual's ineligible spouse who lives in the same household must be deemed to the individual "except to the extent determined by the Secretary to be inequitable under the circumstances." The ALJ referred the case back to SSA for a recomputation of the claimant's deemed income. His decision would have the effect of substantially reducing the amount of income deemed to the claimant from her husband.

Section 1614(c) of the Act defines the term "child" as "an individual who is neither married nor (as determined by the Secretary) the head of a household, and who is (1) under the age of eighteen, or (2) under the age of twenty-two and (as determined by the Secretary) a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment."

Section 416.1160(c) of Regulations No. 16 provides, in pertinent part, that for deeming purposes—"...'Ineligible child' means your natural child, adopted child, or the child of your spouse...who is under age 21, lives in the same household with you, and is not eligible for SSI benefits...'Ineligible spouse' means someone who lives with you as your husband or wife and is not eligible for SSI benefits."

Section 416.1163 of Regulations No. 16 explains how income is deemed to a claimant from his or her ineligible spouse. Paragraph (b) of that section provides that, before income is deemed to a claimant from his or her ineligible spouse, it is reduced by an allocation for ineligible children in the household to help meet their needs.

The general definition of the term "child," as found in section 1614(c) of the Act, does not contain any specific relationship criteria. Nor did the regulations that were in effect at the time of the ALJ's decision contain any relationship criteria in defining the term. After the ALJ's decision was issued, however, SSA published, in final form, new regulations on income and deeming under title XVI of the Act. The preamble to those regulations, published in the Federal Register on October 3, 1980 at 45 FR 65541, indicated that the revisions were intended to reorganize, clarify, and make the regulations easier for the public to understand. As indicated above, §416.1160(c) of the revised regulations includes a specific definition of the term "ineligible child" for deeming purposes, which was not included in the previous regulations.

The revised regulations clearly indicate that an allocation is made only for an individual's natural child, adopted child, or the child of the individual's spouse. There are no provisions for an allocation for grandchildren. Because these new regulations were meant to clarify what had been intended under the previous regulations, the Appeals Council believes they must be applied in this case. Thus, an allocation cannot be made for the claimant's grandchildren for the purpose of reducing the amount of income deemed to her from her husband.

The Appeals Council is of the opinion that Congress did not intend the specific amount of deemed income to be determined by the equities of each individual case. Such a broad standard would be impossible to administer in an effective manner. The Council believes that the formulas for deeming set forth in §§416.1160 through 416.1169, inclusive, of Regulations No. 16 constitute the Secretary's determination of the extent to which it is inequitable to deem income. Consequently, the claimant was ineligible for SSI benefits because the income deemed to her from her husband exceeded the statutory limit.

SECTION 1618 (42 U.S.C. 1382g) SUPPLEMENTAL SECURITY INCOME—PASS-THROUGH PROVISION—CONSTITUTIONALITY

20 CFR 416.2095(b) **SSR 82-29c**

State of Oklahoma, et al. v. Schweiker, 655 F. 2d 461 (D.C. Cir. 1981)

Section 1618 of the Social Security Act (the Act) conditions the receipt of Federal Medicaid funds by States providing supplementary payments under section 1616(a) of the Act or section 212 of P.L. 93-66 on their "passing through" to Supplemental Security Income (SSI) recipients the full amount of Federal cost-of-living increases. The appellants, eleven States, contend that the pass-through provision is an unconstitutional exercise of the Congressional spending power and a violation of the Tenth Amendment because the condition imposed is totally unrelated to the Medicaid program. The appellants also contest the Social Security Administration's (SSA's) interpretation of the scope of section 1618 as applying not only to those who are eligible for both SSI benefits and State supplementation, but to those who, because of their income level, are eligible only for a State supplement. In its review, the court of appeals found that the legislative history of the Act and its amendments show that the pass-through provision is closely tied to the goals of the Medicaid program. It further found that the provision was enacted for the permissible objective of guaranteeing that SSI cost-of-living increases approved by Congress benefit those whom they were designed to assist—SSI recipients, rather than the States. Accordingly, the court of appeals *held* that the pass-through provision of section 1618 is a conventional and appropriate exercise of Congress' authority under the spending clause and is not coercive. The court *further held* that the Secretary's interpretation of section 1618, in 20 CFR 416.2095 (b)(3), to include within its scope recipients who, because of their income, receive only a State supplement accords with the statutory language and is a reasonable exercise of the Secretary's authority to ensure fair and effective administration of the pass-through provision.

MIKVA, Circuit Judge:

Appellants, eleven states,[1] question the constitutionality of the "pass-through" provision of the Supplemental Security Income (SSI) program of the Social Security Act (Act), §§ 1-2007, 42 U.S.C. §§ 301-1397f (1976). The pass-through provision, added to the Act in 1976, conditions the states' receipt of federal Medicaid funds on their "passing through" to SSI recipients annual cost-of-living increases approved by Congress. See Act § 1618, 42 U.S.C. § 1382g (1976). Although similar conditions have previously been imposed by Congress, this device has never before been directly challenged by affected states. Appellants charge that the pass-through provision constitutes an abuse of the federal spending power and violates the Tenth Amendment. They also contest the interpretation given the scope of section 1618 by the Secretary of Health, Education and Welfare.[2]

Seeking declaratory and injunctive relief, the states brought this action in the United States District Court for the District of Columbia. On cross-motions for summary judgment, the court below granted judgment in favor of the federal government.[3] We affirm that order.

I. THE LEGISLATIVE SCHEME

A. *Statutory Background*

The Social Security Act was enacted in 1935 as "a series of related measures designed as a unified, well-rounded program of attack upon the principal causes of insecurity in our economic life." S. Rep. No. 628, 74th Cong., 1st Sess. 2 (1935). It contained a number of titles pertaining to five broad subject areas: old-age security, unemployment compensation, aid to dependent children, public health measures, and aid to the blind. Titles I and X established grant programs enabling the states to assist, respectively, the aged and the blind. Title XIV, added to the Act in 1950, provided grants to the states for the benefit of the permanently and totally disabled.

Under these titles, the federal government reimbursed the states for part of the cost of cash payments made to assist the needy in acquiring food, shelter, and medical care. The states administered the programs and determined the levels of assistance, but they had to comply with various federal requirements in order to receive federal matching funds.

The Social Security Amendments of 1960, also referred to as the Kerr-Mills Act, provided additional financial incentives to induce states to improve medical care to the elderly. The new provisions were added to Title I, the basic assistance program for the aged. The House report indicated that state plans which attempted to finance the new health care programs by diverting funds from existing public assistance programs were to be disapproved. See H.R. Rep. No. 1799, 86th Cong., 2d Sess. 8 (1960).

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[1] Appellants are the states of Alabama, Connecticut, Florida, Idaho, Illinois, Louisiana, Missouri, Nebraska, Oklahoma, Virginia, and Washington. Colorado and Michigan were parties below but have not joined in this appeal.

[2] That Department has been redesignated the Department of Health & Human Services, see 20 U.S.C. § 3508 (Supp. III 1979), but will be referred to here by its former title, which was in effect when appellants filed their complaint.

[3] See *Oklahoma v. Harris*, 480 F. Supp. 581 (D.D.C. 1979).

In 1962, Title XVI was enacted, which permitted states to consolidate their assistance programs for the aged, the blind, and the disabled. To encourage the states to take advantage of this legislation, Congress provided a more favorable ratio of federal matching funds for medical assistance to the blind and the disabled under a combined plan than under the former separate plans.

The Medicaid program, Title XIX of the Act, was established by the Social Security Amendments of 1965 and is now the largest federal-state matching fund program. See *Oklahoma v. Harris*, 480 F. Supp. 581, 583 (D.D.C. 1979). The states were authorized by these amendments to set up comprehensive plans for supplying medical services to the needy. Health care providers were reimbursed by the states for the cost of medical care furnished to Medicaid recipients, and the states in turn recouped a portion of their expenditures from the federal government. The Medicaid program was designed to replace and consolidate the previously separate health care components of the states' various cash assistance programs. Congress directed that no state Medicaid plan was to be approved if it resulted in a reduction of basic maintenance assistance to the needy. See Act § 1902(c), 42 U.S.C. § 1396a(c) (1976).

Cash assistance programs for the aged, the blind, and the disabled were federalized in 1972 with the establishment of the Supplemental Security Income program. The SSI program is described in Title XVI of the Act, which Congress revised to replace the old Titles I, X, XIV, and XVI. The federal government assumed responsibility for the administration and much of the cost of the former assistance programs; it also determined eligibility criteria for beneficiaries and set a uniform level of benefits to be given to all recipients.

This uniform national payment exceeded the assistance received by aid recipients under the superseded state-administered programs in some states, and was less than that received by recipients in other states. In order to ensure that no one suffered as a result of the new program, Congress determined that states whose grant programs had set assistance levels higher than the federal level should be required to make supplementary payments. Accordingly, Congress conditioned a state's eligibility for Medicaid funds on its willingness to make up any shortfall between the federal SSI benefit and the amount a beneficiary received from the state program as of December, 1973. See, Pub. L. No. 93-66, § 212, 87 Stat. 155 (1973), 42 U.S.C. § 1382 note (1976).[4]

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[4] The federal government agreed to reimburse a state for any difference between the amount of state funds paid in 1972 under the original matching fund program and the amount required in supplementary payments to maintain benefits at the 1972 level. See Pub. L. No. 92-603, § 401, 86 Stat. 1485 (1972), 42 U.S.C. § 1382e note (1976). As a result of increases in the federal SSI benefit level, this "hold-harmless" clause now affects only three states—Hawaii, Massachusetts, and Wisconsin—none of which is a party to this case.

Moreover, Congress encouraged the states to provide optional supplementary aid both to SSI recipients and to those who, though needy, do not meet federal eligibility standards under Title XVI. See Act § 1616, 42 U.S.C. § 1382e (1976); H.R. Rep. No. 231, 92d Cong., 1st Sess. 199 (1971). Although this assistance comes entirely from state funds,[5] the federal government will, at the state's request, administer the payments at no cost to the state. See Act § 1616, 42 U.S.C. § 1382e (1976). Most states have chosen to provide supplementary assistance, see 122 Cong. Rec. 34,543 (1976) (remarks of Sen. Humphrey); *id.* at 28,280 (remarks of Rep. O'Neill), and it was the reduction of such payments that led Congress to enact the pass-through provision.

B. *The Pass-Through Provision*

Title XVI guarantees SSI recipients automatic, annual cost-of-living increases based on the Consumer Price Index. *See* Act § 1617, 42 U.S.C. § 1382f (1976). These increases began in 1974 but have been offset in many states by a simultaneous reduction in the level of the state supplementary payment—sometimes by an amount equal to the cost-of-living increase, at other times by a lesser amount.[6] Thus, SSI recipients in those states have been denied the full benefit of the cost-of-living rises approved by Congress. Instead, the increased federal expenditures have gone to provide fiscal relief to the states.

In order to prevent this result, Congress enacted the pass-through provision in 1976. See Act § 1618, 42 U.S.C. § 1382g (1976). This section conditions states' receipt of federal Medicaid funds on their agreement to pass through to SSI recipients the full amount of the annual federal cost-of-living increases. A state that supplements federal SSI assistance must maintain those supplementary payments at a level no lower than that in effect in December, 1976, or in the first subsequent month in which supplementary payments are made. *See id.* § 1618(a), 42 U.S.C. § 1382g(a). A state is in compliance with this condition if its total expenditure on supplementary payments in any twelve-month period is no less than the amount spent in the preceding twelve months. *See id.*

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[5] The only exception is due to the hold-harmless clause of the Act. See note 4 *supra*.

[6] For example, only thirteen states passed through the entire 1976 SSI cost-of-living increase, while eight states passed through part of that increase. See 122 Cong. Rec. 24,455-56 (1976) (remarks of Rep. Fraser); see *also id.* at 34,543 (remarks of Sen. Humphrey) (similar figures for 1975).

§ 1618(b), 42 U.S.C. § 1382g(b).[7] The states are not obligated to increase the level of supplementary benefits—for example, to keep pace with inflation—but they must maintain the 1976 level of those payments.[8]

Appellants contend that this provision is an unconstitutional exercise of the congressional spending power and a violation of the Tenth Amendment because the condition imposed is totally unrelated to the Medicaid program. We turn now to discuss those allegations.

II. THE SPENDING POWER

A. *The Applicable Principles*

Appellants maintain that section 1618 exceeds congressional authority under the spending clause, which gives Congress the "Power To lay and collect Taxes . . . to . . . provide for the . . . general Welfare of the United States." Art. I, § 8, cl. 1. Appellants observe that none of Congress' enumerated powers permit it to require the states to devote a certain portion of their budgets to welfare programs. And they insist that that result may not be accomplished indirectly via the terms imposed by the pass-through condition, which is not related to the federal spending program conditioned, that is, Medicaid. On the other hand, the court below ruled, and appellees argue, that Congress may condition the receipt of federal benefits "[s]o long as the statute is reasonably related to the general welfare and is enacted in furtherance of the Congressional power to tax and to spend under the Constitution." 480 F. Supp. at 586.

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[7] Section 1618 provides in full:

> (a) In order for any State which makes supplementary payments of the type described in section 1382e(a) of this title (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66), on or after June 30, 1977, to be eligible for payments pursuant to subchapter XIX of this chapter with respect to expenditures for any calendar quarter which begins—
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> (1) after June 30, 1977, or, if later,
>
> (2) after the calendar quarter in which it first makes such supplementary payments,
>
> such States must have in effect an agreement with the Secretary whereby the State will—
>
> (3) continue to make such supplementary payments, and
>
> (4) maintain such supplementary payments at levels which are not lower than the levels of such payments in effect in December 1976, or, if no such payments were made in that month, the levels for the first subsequent month in which such payments were made.
>
> (b) The Secretary shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) of this section with respect to the levels of its supplementary payments for a particular month or months if the State's expenditures for such payments in the twelve-month period (within which such month or months fall) beginning on the effective date of any increase in the level of supplemental security income benefits pursuant to section 1382 of this title are not less than its expenditures for such payments in the preceding twelve-month period.

42 U.S.C. § 1382g (1976).

[8] See notes 20 & 22 *infra*. In the three hold-harmless states, *see* notes 4 & 5 *supra* & accompanying text, Congress prohibited the federal government from failing to pass through an SSI cost-of-living increase by reducing its payments to support the state level of supplementation. See Pub. L. No. 94-585, § 2(b), 90 Stat. 2902 (1976), 42 U.S.C. § 1382e note (1976).

We note initially that Congress' lack of authority to mandate directly the result it hopes to encourage by means of the pass-through provision is not an appropriate measure of congressional jurisdiction under the spending clause. The Supreme Court has long recognized that the power to spend for the general welfare is not limited by the direct grants of congressional power enumerated in article I. Rather, the general welfare clause is itself an independent—and expansive—source of Congress' spending authority. *See Fullilove v. Klutznick*, 100 S. Ct. 2758, 2772 (1980) (opinion of Burger, C.J.); *Buckley v. Valeo*, 424 U.S. 1, 90-91 (1976) (per curiam); *United States v. Butler*, 297 U.S. 1, 66 (1936). Moreover, Congress' determination of what constitutes the general welfare is entitled to a good deal of deference. In *Butler*, the Supreme Court noted that one who contests congressional exercises of the spending power must show that "by no reasonable possibility can the challenged legislation fall within the wide range of discretion permitted to the Congress." *Id.* at 67. Similarly, in *Helvering v. Davis*, 301 U.S. 619, 640 (1937), the Court held that a decision by Congress in this area may not be overturned "unless the choice is clearly wrong, a display of arbitrary power, [and] not an exercise of judgment."

In addition to Congress' broad power to spend for the general welfare, its ability to impose conditions on the receipt of federal funds is also unquestioned. As the Supreme Court held in *Oklahoma v. United States Civil Service Comm'n*, 330 U.S. 127, 144 (1947), "[t]he offer of benefits to a state by the United States dependent upon cooperation by the state with federal plans, assumedly for the general welfare, is not unusual." *See also Fullilove*, 100 S. Ct. at 2772 (opinion of Burger, C.J.); *Massachusetts v. United States*, 435 U.S. 444, 461 (1978) (plurality); *Lau v. Nichols*, 414 U.S. 563, 569 (1974); *King v. Smith*, 392 U.S. 309, 333 n.34 (1968); *Ivanhoe Irrigation District v. McCracken*, 357 U.S. 275, 295 (1958); *Steward Machine Co. v. Davis*, 301 U.S. 548, 590-91 (1937).

The conditions that Congress may set in disbursing federal funds are not restricted to those areas over which Congress has direct regulatory authority. *See, e.g., Oklahoma v. United States Civil Service Comm'n*, 330 U.S. at 143. Although there may be some limit to the terms Congress may impose, we have been unable to uncover any instances in which a court has invalidated a funding condition.[9] Several times the Supreme

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[9] For circuit and district court decisions upholding conditions imposed under the congressional spending power, see, e.g., *County of Los Angeles v. Marshall*, 631 F.2d 767 (D.C. Cir.), *cert. denied*, 101 S. Ct. 113 (1980); *New Hampshire Dep't of Employment Security v. Marshall*, 616 F.2d 240 (1st Cir.), *appeal dismissed*, 101 S. Ct. 53 (1980); *County of Los Angeles v. Adams*, 574 F.2d 607 (D.C. Cir. 1978) (per curiam); *Florida v. Mathews*, 526 F.2d 319 (5th Cir. 1976); *Arizona State Dep't of Public Welfare v. Department of Health, Education & Welfare*, 449 F.2d 456 (9th Cir. 1971), *cert. denied*, 405 U.S. 919 (1972); *Texas Landowners Rights Ass'n v. Harris*, 453 F. Supp. 1025 (D.D.C. 1978), *aff'd mem.*, 598 F.2d 311 (D.C. Cir.), *cert. denied*, 444 U.S. 927 (1979); *Florida Dep't of Health & Rehabilitative Servs. v. Califano*, 449 F. Supp. 274 (N.D. Fla.), *aff'd mem.*, 585 F.2d 150 (5th Cir. 1978), *cert. denied*, 441 U.S. 931 (1979); *North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532 (E.D.N.C. 1977) (three-judge court), *aff'd mem.*, 435 U.S. 962 (1978); *City of Macon v. Marshall*, 439 F. Supp. 1209 (M.D. Ga. 1977); *Stiner v. Califano*, 438 F. Supp. 796 (W.D. Okla. 1977) (three-judge court); *Dupler v. City of Portland*, 421 F. Supp. 1314 (D. Me. 1976); *Vermont v. Brinegar*, 379 F. Supp. 606 (D. Vt. 1974).

Court has spefically [sic] declined to articulate the precise boundaries of Congress' discretion, *see Fullilove*, 100 S. Ct. at 2773 (opinion of Burger, C.J.); *Lau*, 414 U.S. at 569; *Butler*, 297 U.S. at 67, and we see no need for this court to do so here. As discussed in part II(B) *infra*, we are satisfied that the pass-through provision represents an appropriate exercise of Congress' spending power, and we find that appellants have erred in characterizing the terms imposed by section 1618 as completely unrelated to Medicaid, the program conditioned.

Before considering those points, we reject the rigid nexus test proposed by appellants for determining the propriety of restrictions Congress sets on the use of federal funds. Appellants maintain that a condition must be precisely related to the purpose of the federal funds whose receipt is conditioned: they urge the court to approve only those conditions aimed at serving the same federal interest served by the funding program conditioned here, Medicaid. That standard is not supported by the case law.

In *Oklahoma v. United States Civil Service Comm'n*, for example, federal highway funds were withheld from the state in an amount equal to two years' compensation of a state highway official who had violated the Hatch Act's prohibition of participation in political campaigns, § 12(b), 18 U.S.C. § 611(b) (1946) (current version at 5 U.S.C. § 1506(a) (1976)). Similarly, in *Lau*, the Court approved a spending condition based on section 601 of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (1976), which broadly proscribes discrimination on the ground of race or national origin in "any program or activity receiving Federal financial assistance." And in *Fullilove*, the Court upheld a provision of the Public Works Employment Act of 1977, § 103(f) (2), 42 U.S.C. § 6705(f) (2) (Supp. III 1979), conditioning receipt of public works grants on an agreement by the state or local government grantee that at least ten percent of federal funds will be allocated to contracts with minority businesses. *See also District of Columbia v. Train*, 521 F.2d 971, 993 n.26 (D.C. Cir. 1975) (citing section 2 of the Emergency Highway Energy Conservation Act, Pub. L. No. 93-239, 87 Stat. 1046 (1974), 23 U.S.C. § 101 note (1976) (repealed 1975), which conditioned receipt of federal highway funds on state's enforcement of fifty-five-mile-per-hour speed limit), *vacated and remanded on other grounds sub nom. EPA v. Brown*, 431 U.S. 99 (1977) (per curiam); *Texas Landowners Rights Ass'n v. Harris*, 453 F. Supp. 1025 (D.D.C. 1978) (upholding provision that denies both direct federal financial assistance for acquisition or construction purposes and mortgage money from federally supervised private institutions if community fails to participate in national flood insurance plan), *aff'd mem.*, 598 F.2d 311 (D.C. Cir.), *cert. denied*, 444 U.S. 927 (1979); *City of Macon v. Marshall*, 439 F. Supp. 1209 (M.D. Ga. 1977) (approving denial of federal mass transit grant to city that refused to continue collective bargaining rights of bus company employees).

In each of these cases, the condition imposed by Congress, and the behavior of the grant recipient that the condition was designed to affect, were not exactly correlated to the purpose for which the conditioned federal funds were dispensed: the conditions and the general funding programs were aimed at serving different federal interests.

Nevertheless, the courts recognized that in each instance Congress had legitimately exercised its power to insist that those receiving federal benefits agree, in exchange, to abide by the condition set by Congress. In none of the cases did the courts require that Congress identify the relationship between the terms imposed and the purposes of the funding programs conditioned. Congress' constitutional power to fix conditions on the use of federal funds may not be held to the modest limits proposed by appellants.[10]

B. *The Controversy Here*

The condition imposed by the pass-through provision is clearly in line with the statutes upheld in the Supreme Court precedents cited above. The Court has long recognized that alleviating the economic insecurity of the needy is a legitimate congressional concern and one that may appropriately be pursued by use of the spending power. *See, e.g., Helvering v. Davis*, 301 U.S. 619, 644 (1937); *Steward Machine Co. v. Davis*, 301 U.S. 548, 593 (1937). Congress' purpose in enacting the pass-through provision was to ensure that cost-of-living increases approved by Congress would inure to the benefit of those whom the funds were designed to assist—SSI recipients, rather than the states. *See, e.g.*, 122 Cong. Rec. 34,543, 33,271, 28,278-84, 27,280-81 (1976). As Senator Humphrey noted:

> [T]he Congress did not intend for SSI recipients to lose ground by passing the cost-of-living increase. And our intent was not to provide budget support to State government. We have revenue sharing. We have other categorical programs which funnel funds into the States. This is not a State Assistance program. It is a program to aid the elderly, the blind, and the disabled.

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[10] Appellants insist that dictum in two Supreme Court cases supports the nexus requirement they propose. *See Massachusetts v. United States*, 435 U.S. 444, 461 (1978) (plurality) ("We have repeatedly held that the Federal Government may impose appropriate conditions on the use of federal property or privileges and may require that state instrumentalities comply with conditions that are reasonably related to the federal interest in particular national projects or programs."); *Ivanhoe Irrigation Dist. v. McCracken*, 357 U.S. 275, 295 (1958) ("Also beyond challenge is the power of the Federal Government to impose reasonable conditions on the use of federal funds, federal property, and federal privileges . . . [T]he Federal Government may establish and impose reasonable conditions relevant to federal interest in the project and to the over-all objectives thereof.").

Neither of these cases involved an argument that a term set by Congress was unrelated to the federal funds conditioned. In fact, in *Massachusetts* a user charge imposed on the states was challenged on the ground that states are immune from federal taxes; the plurality mentioned the spending power only by way of analogy. Moreover, in neither case did the Court adopt the rigid test advanced by appellants. The language quoted above may indicate only that the spending power must be exercised for the general welfare—that is, that a condition exceeds Congress' power if it is "unrelated in subject matter to activities fairly within the scope of national policy and power." *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937); *see also United States v. Butler*, 297 U.S. 1, 66-67 (1936); *Texas Landowners Rights Ass'n v. Harris*, 453 F. Supp. 1025, 1030 (D.D.C. 1978), *aff'd mem.*, 598 F.2d 311 (D.C. Cir.), *cert. denied*, 444 U.S. 927 (1979); *North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532, 535 (E.D.N.C. 1977) (three-judge court), *aff'd mem.*, 435 U.S. 962 (1978); *Vermont v. Brinegar*, 379 F. Supp. 606, 616 (D. Vt. 1974).

Id. at 34,543.

Guaranteeing the proper use of federal funds is certainly an appropriate congressional concern, and one of the typical justifications for attaching conditions to grant programs. *See, e.g., North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532, 534-35 (E.D.N.C. 1977) (three-judge court) (federal health care grants conditioned on state's establishing a health planning agency that would approve development only of needed new health services; condition designed to ensure efficient use of federal funds), *aff'd mem.*, 435 U.S. 962 (1978); *Dupler v. City of Portland*, 421 F. Supp. 1314 (D. Me. 1976) (federal food stamp funds conditioned on state's not reducing welfare payments and similar aid). Here, Congress' objective could not be realized by amending Title XVI of the Act, the portion relating to SSI, because it is individual needy persons, not the states, that are entitled to the funds allocated to the SSI program. In order to induce the states to pass cost-of-living increases on to aid recipients, Congress deemed it necessary to attach the pass-through condition to the Medicaid provisions of the Act, under which funds are disbursed to the states. We do not find that this choice—involving the structure of the Social Security Act and the various methods used to disburse funds—renders the condition impermissible.

Appellants allege, however, that the condition is unconstitutional because there is no relationship between a state's supplementary payments, which are meant to be optional and to augment the uniform SSI benefit level set by Congress, and the Medicaid program, which provides basic medical assistance to the needy. We find this an overly simplistic and compartmentalized characterization of the Social Security Act. Even were we to accept appellants' suggestion that no link connects *state* supplementary benefits and Medicaid,[11] we could not invalidate the pass-through condition. Appellants' description of section 1618 ignores the basic legislative purpose, which was not regulation of state supplementation programs. Congress did not mandate that states increase the level of supplementary benefits or devote a greater portion of their budgets to assistance programs. It only directed that SSI money appropriated by Congress for the benefit of the needy be spent on their behalf. The pass-through provision is therefore in essence a condition relating to the SSI program, not to state supplementary programs. Viewed in this way, section 1618 is permissible even under appellants' rigid nexus test: the assurance of SSI benefits—the purpose of the pass-through requirement—is closely tied to the goals of the Medicaid program.

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[11] We note, however, that Congress has acknowledged the importance of state supplementation to the federal government's effort to alleviate economic insecurity—the goal of both the Medicaid program and SSI, see text accompanying notes 12-14 *infra*. Congress encouraged the states to furnish optional supplementary aid to the needy when it established the SSI program. See H.R. Rep. No. 231, 92d Cong., 1st Sess. 199 (1971). The legislative history of the pass-through provision similarly reflects congressional recognition of the necessity of state supplementation. *See, e.g.*, 122 Cong. Rec. 28,284, 28,283, 28,280, 24,455 (1976) (remarks of, respectively, Reps. Daniels, Abzug, O'Neill, Fraser).

Appellants complain, however, that the states were led to believe that supplementation of SSI benefits was completely discretionary and could be reconsidered at any time. See H.R. Rep. No. 231, 92d Cong., 1st Sess. 199 (1971). But states cooperating with the federal government under the SSI program were clearly to be subject to such conditions "as the Secretary [found] necessary for effective and efficient administration." *Id.* at 200. Moreover, as the Supreme Court pointed out in *Helvering v. Davis*, 301 U.S. 619, 641 (1937), Congress' decisions regarding use of the spending power may change over time for "the concept of the general welfare [is not] static." In enacting the pass-through provision, Congress clearly spoke unambiguously enough to enable the states to make an informed choice whether to accept the terms imposed. *Cf. Pennhurst State School & Hospital v. Halderman*, 101 S. Ct. 1531, 1539-45 (1981).

Indeed, SSI and Medicaid are two interrelated components of the comprehensive federal effort to aid the aged, the blind, and the disabled. Both programs are aimed at the same target population—in fact, eligibility for SSI payments automatically entitles one to Medicaid benefits in most states[12]—but each focuses on satisfying a particular need. Under the SSI program, recipients are provided cash benefits to be used for basic subsistence, whereas Medicaid is designed to furnish needed medical services.

The relationship between the two programs is not surprising. As Congress has long acknowledged, the cost of medical care is one of the factors determining need, and there is a causal relationship between economic insecurity and ill health. See, e.g., H.R. Rep. No. 1300, 81st Cong., 1st Sess. 41 (1949); S. Rep. No. 628, 74th Cong., 1st Sess. 21 (1935); H.R. Rep. No. 615, 74th Cong., 1st Sess. 13 (1935). When, in 1935, Congress wished to make a "unified . . . attack" on the various causes of economic dependence, it naturally provided funds for both medical services and basic subsistence needs. S. Rep. No. 628, 74th Cong., 1st Sess. 2 (1935). The Social Security Act thus comprised a number of measures, each "closely related to the others," that "together . . . constitute[d] a broad, practicable plan to safeguard the security of the American family." *Id.*

As originally enacted, the Act was structured according to type of recipient: Title I pertained to the aged, Title X to the blind, and Title XIV to the disabled. Each title included provisions relating to both health and welfare benefits. When the Social Security Amendments of 1960 created additional financial incentives to tempt the states to improve medical care to the elderly, the new health care provisions were added to Title I, the basic assistance program for the aged.

This categorical approach to aid programs proved cumbersome, and the organization of the statute gradually shifted so that classifications were made according to type of benefit. In 1962, the former Title XVI was enacted, which encouraged the states to combine their assistance programs for the aged, the blind, and the disabled. The medical assistance components of these programs were then consolidated in 1965 with passage of Title XIX, the Medicaid provisions. The Medicaid portion of the statute still covers medical services, while SSI was established in 1972 to provide basic assistance benefits. The route to the present statutory structure has been convoluted. But the process demonstrates that Medicaid and SSI are not independent programs; rather, their current form has evolved from an original statutory structure which clearly indicates that Congress views medical benefits and basic subsistence payments as components of one overall scheme.

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[12] The Act provides that states may treat SSI recipients as automatically eligible for Medicaid. See Act § 1902(a)(10), 42 U.S.C. § 1396a(a)(10)(1976). Alternatively, a state may determine Medicaid eligibility by other criteria, which may be no more restrictive than those applicable to the state's cash assistance program on January 1, 1972. See *id.* § 1902(f), 42 U.S.C. § 1396a(f). Fifteen states have chosen the latter option. See Brief for Amicus Curiae at 6-7.

Our interpretation is corroborated by other exercises of the congressional power to condition the use of social security funds; the pass-through provision is by no means unique in limiting a state's ability to reduce its welfare expenditures in return for federal medical care funds. For example, the Act directs the Secretary to disapprove state Medicaid plans that result in a decrease of basic subsistence payments. See Act § 1902(c), 42 U.S.C. § 1396a(c) (1976). This provision was enacted in recognition of "the need and urgency for states to maintain, if not improve, the level of basic maintenance provided for needy people under the public assistance programs," and its purpose was to "prevent any unwarranted diversion of funds from basic maintenance to medical care." S. Rep. No. 404, pt. 1, 89th Cong., 1st Sess. 82-83 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 72 (1965). Similarly, the Kerr-Mills Act required that state plans for medical care for the aged be rejected if they were to be financed by diverting funds from existing state assistance programs. Moreover, when the SSI program was initiated, and a uniform federal benefit level set, Congress conditioned receipt of Medicaid funds on state guarantees that recipients under the former state programs would suffer no decrease in benefits. A state that had been making assistance payments greater than the uniform SSI benefit level was thus required to make up the difference to all those on its welfare rolls as of December, 1973. See Pub. L. No. 93-66, § 212, 87 Stat. 155 (1973), 42 U.S.C. § 1382 note (1976).[13]

The legislative history of the Social Security Act and of its amendments therefore refutes appellants' suggestion that the requirement that states pass through SSI cost-of-living increases is unrelated to the purposes of the Medicaid program. On the contrary, the relevant committee reports, the evolution of the Act's structure, and other conditions set by Congress all indicate that Medicaid funds and SSI benefits are two elements of one scheme with a single aim. We find nothing impermissible in Congress' conditioning a state's receipt of Medicaid funds on its compliance with section 1618's mandate regarding the use of SSI funds.[14]

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[13] *See also* 122 Cong. Rec. 33,272 (1976).

> Mr. HUMPHREY. . . . My amendment, as the Senator knows, would not require any State to increase its supplementary aid to any SSI recipient. It would only require that the States not reduce their level of support.
>
> We did that in revenue sharing. In revenue sharing we required that State governments are required to maintain their intergovernmental transfers to all units of local government at fiscal 1972 levels.
>
> Mr. LONG. In one way or another, time and again we have done things such as the Senator is suggesting.

We note that this result is consistent with our reluctance to become excessively involved in the legislative process. In general, the courts do not dictate to Congress the appropriate method for drafting statutes. It is up to Congress to decide whether the Social Security Act should be structured according to type of recipient, or according to type of benefit, and whether all funds should be disbursed in the same way, or some given directly to the recipients and others to the states.[15] Likewise, Congress need not make specific findings about the relationship between a condition to be imposed on the disbursement of federal funds and the grant program conditioned.[16] And the wisdom of the terms set by Congress is not an appropriate concern of ours. *See Rosado* v. *Wyman*, 397 U.S. 397, 422 (1970). At some point, Congress' power to enforce restrictions on the use of federal money may be limited. But we see no need to explore the boundaries of Congress' discretion in a case in which the condition imposed clearly serves a legitimate federal interest and is designed to effect the purposes of the statute to which it is attached.

III. THE TENTH AMENDMENT

Closely related to appellants' spending power argument is their challenge to the pass-through provision as violative of the Tenth Amendment.[17] Appellants claim that section 1618 unconstitutionally diminishes the states' sovereign power by dictating budget choices. The Tenth Amendment claim is based, once again, on the absence of a relationship between the condition and the funds conditioned and, additionally, on the Supreme Court's opinion in *National League of Cities* v. *Usery*, 426 U.S. 833 (1976). The first ground is as unpersuasive in this context as it was when advanced with respect to the congressional spending power. As discussed above in part II, we find appellants' nexus test overly rigid and inconsistent with the case law, and we discern a reasonable connection between the purpose of section 1618—to ensure that SSI cost-of-living increases benefit assistance recipients—and the goals of the Medicaid program.

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[14] Appellants argue, however, that the legislative history of section 1618 evidences no consideration by Congress of the relationship between that provision and the Medicaid program. We do not find the lack of discussion surprising or significant. The earlier legislative history of the Act and the conditions similar to the pass-through provision previously imposed by Congress suggest that the relationship between Medicaid and SSI is so well-accepted as to be implicit. Moreover, this court's duty is to interpret legislation; we do not generally instruct Congress on the type of findings it should make, or the type of discussions it should have, before passing a bill.

[15] We assume, for example, that appellants would have no objection were the Act still structured according to type of beneficiary, and had Congress conditioned receipt of health care funds to assist the aged on a state's agreement to share responsibility for the cost of providing subsistence benefits to that group. The condition and the restricted funds would then involve the same program, the same title of the statute, and the same beneficiaries. We find no substantive distinction between this hypothetical and the case at bar.

[16] At oral argument, counsel for appellants admitted that the states' argument would be weaker if Congress had included in section 1618 a finding about the relationship between Medicaid and the pass-through condition.

[17] "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." Amend. X.

Second, *National League of Cities* by no means compels invalidation of the pass-through provision. In that case, the Court overturned 1974 amendments to the Fair Labor Standards Act which extended the statute's wage and hour requirements to most state government employees. *See* 29 U.S.C. § 203(d), (s)(6), (x) (1976 & Supp. III 1979). The Court found that insistence that state governments adhere to those provisions exceeded Congress' power under the commerce clause, art. I, § 8, cl. 3, and violated the Tenth Amendment. As every court reviewing challenges similar to that before us has held, the Supreme Court's opinion is distinguishable on two grounds.

First, the wage and hour provisions invalidated in *National League of Cities* were held to be in excess of Congress' power under the *commerce* clause. The Supreme Court specifically declined to rule whether Congress could permissibly use its authority under the *spending* clause to "seek to affect integral operations of state governments." 426 U.S. at 852 n.17. Although Congress may not direct the budgetary decisions of the states, it may set conditions on the grant of federal funds. As the Supreme Court held in *Oklahoma v. United States Civil Service Comm'n*, 330 U.S. 127, 143 (1947), "[w]hile the United States is not concerned with, and has no power to regulate, local political activities as such of state officials, it does have power to fix the terms upon which its money allotments to states shall be disbursed." *National League of Cities* did nothing to repudiate that decision or the long line of cases, discussed in part II(A) *supra*, that permit Congress to impose conditions on the use of federal grants. This court has thus refused to extend *National League of Cities* to Tenth Amendment challenges to congressional action based on the spending power. *See County of Los Angeles v. Marshall*, 631 F.2d 767, 769 (D.C. Cir.), *cert. denied*, 101 S. Ct. 113 (1980). Other courts have ruled similarly.[18]

Second, the Fair Labor Standards Act amendments at issue in *National League of Cities* mandated that state employees receive certain wages and work a certain number of hours. The states were left with minimal discretion in implementing those provisions and were subject to civil and criminal penalties for violations. The Supreme Court thus found that the Act "*directly displace[d]* the States' freedom to structure integral operations in areas of traditional governmental functions" and "appear[ed] likely to have the effect of *coercing* the States to structure work periods . . . in a manner substantially different from the practices which [had] long been commonly accepted among local governments of this Nation." 426 U.S. at 852, 850 (emphasis supplied). Conditioning the receipt of federal grants does not similarly impose a direct restriction on states' decisionmaking: they may choose to conform to federal requirements or to forego federal funds. This circuit has therefore held that *National League of Cities* does not invalidate congressional attempts to induce state cooperation with federal plans. *See County of Los Angeles v. Marshall*, 631 F.2d at 769; *County of Los Angeles v. Adams*, 574 F.2d 607, 609 (D.C. Cir. 1978) (per curiam); *Texas Landowners Rights Ass'n v. Harris*, 453 F. Supp. 1025, 1029-30 (D.D.C. 1978), *aff'd mem.*, 598 F.2d 311 (D.C. Cir.), *cert. denied*, 444 U.S. 927 (1979). *See also District of Columbia v. Train*, 521 F.2d 971, 992-93 (D.C. Cir. 1975) (distinguishing congressional efforts to compel and to encourage before *National League of Cities*), *vacated and remanded on other grounds sub nom. EPA v. Brown*, 431 U.S. 99 (1977) (per curiam). Again, the decisions of other courts are in agreement.[19]

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[18] *See, e.g.*, *New Hampshire Dep't of Employment Security v. Marshall*, 616 F.2d 240, 247 (1st Cir.), *appeal dismissed*, 101 S. Ct. 53 (1980); *Florida Dep't of Health & Rehabilitative Servs. v. Califano*, 449 F. Supp. 274, 284 (N.D. Fla.), *aff'd mem.*, 585 F.2d 150 (5th Cir. 1978), *cert. denied*, 441 U.S. 931 (1979); *North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532, 536 n.10 (E.D.N.C. 1977) (three-judge court), *aff'd mem.*, 435 U.S. 962 (1978); *Dupler v. City of Portland*, 421 F. Supp. 1314, 1320 (D. Me. 1976). *Cf. Usery v. Charlestown County School Dist.*, 558 F.2d 1169, 1170-71 (4th Cir. 1977) (refusing to extend *National League of Cities* to Tenth Amendment challenge to legislation based on congressional authority under § 5 of the Fourteenth Amendment); *Usery v. Allegheny County Institution Dist.*, 544 F.2d 148, 154-55 (3d Cir. 1976) (same), *cert. denied*, 430 U.S. 946 (1977).

In this case, unlike *National League of Cities*, states are required to make no changes in policy but need only maintain their current level of assistance expenditures.[20] In *National League of Cities* itself, the Supreme Court distinguished the costly wage and hour requirements of the Fair Labor Standards Act from the provisions of the Economic Stabilization Act of 1970, Pub. L. No. 91-379, 84 Stat. 799 (1970), 12 U.S.C.

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[19] *See, e.g.*, *New Hampshire Dep't of Employment Security v. Marshall*, 616 F.2d 240, 245 (1st Cir.), *appeal dismissed*, 101 S. Ct. 53 (1980); *Florida Dep't of Health & Rehabilitative Servs. v. Califano*, 449 F. Supp. 274, 283-84 (N.D. Fla.), *aff'd mem.*, 585 F.2d 150 (5th Cir. 1978), *cert. denied*, 441 U.S. 931 (1979); *North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532, 536 & n.10 (E.D.N.C. 1977) (three-judge court), *aff'd mem.*, 435 U.S. 962 (1978); *City of Macon v. Marshall*, 439 F. Supp. 1209, 1217 (M.D. Ga. 1977); *Dupler v. City of Portland*, 421 F. Supp. 1314, 1320 & n.8 (D. Me. 1976).

[20] Not only are the states subject to no requirement that they increase expenditures on assistance programs, but they save roughly $124 million as a result of the enactment of SSI and federalization of aid programs: appellants spent approximately $317 million on aid to the aged, blind, and disabled in 1973 but only some $193 million in supplementary payments in 1976. See Defendants' Statement of Material Facts as to Which There Is No Genuine Issue at 2, *reprinted in* Joint Appendix (J.A.) at 30, 31; *cf.* Plaintiffs' Statement in Response to Defendants' Statement of Material Facts as to Which There Is No Genuine Issue at 1, *reprinted in* J.A. at 32, 32 (calculating appellants' 1976 supplementary payments as totalling $199 million). *But see generally Reichenthal v. Harris*, 492 F. Supp. 637, 640 (E.D.N.Y. 1980).

Appellants assert that the pass-through provision will entail increased costs for the states because caseload fluctuations and forecasting difficulties will prevent a state from being able to maintain exactly its total expenditures from the prior year. In order to avoid the risk of being found in noncompliance, appellants continue, the state will likely increase expenditures. The Secretary foresaw this problem, however, and the regulations permit a state to correct a shortfall for any twelve-month period by making it up during the subsequent year or by making a single retroactive payment to affected beneficiaries. See 45 Fed. Reg. 54,742, 54,744, 54,749-50 (1980) (to be codified at 20 C.F.R. § 416.2096). *See also* note 22 *infra*.

§ 1904 note (1976), approved in *Fry v. United States*, 421 U.S. 542 (1975). That statute had authorized the President to freeze temporarily the wages paid state and local government employees in order to combat inflation. Such congressional action, the Court indicated in *National League of Cities*, was not contrary to the Tenth Amendment because, among other things, the freeze

> displaced no state choices as to how governmental operations should be structured, nor did it force the States to remake such choices themselves. Instead, it merely required that the wage scales and employment relationships which the States themselves had chosen be maintained during the period of the emergency.

426 U.S. at 853. That reasoning is equally applicable to the provision at issue in this case.

Other courts have approved more onerous conditions attached to federal spending programs, even though they interfere to some extent with state decisionmaking. Some such statutes have entailed substantially increased outlays of funds. *See, e.g.*, *Lau v. Nichols*, 414 U.S. 563, 568 (1974) (affirmative steps to alleviate language barriers preventing equal education opportunity); *Rosado v. Wyman*, 397 U.S. 397, 421 (1970) (adjustment of state calculations of need to reflect changes in cost of living; incremental cost "massive"); *County of Los Angeles v. Marshall*, 631 F.2d at 768 (extension of unemployment benefits to state employees); *New Hampshire Dep't of Employment Security v. Marshall*, 616 F.2d 240, 248 (1st Cir.) (same; cost estimated as high as 1.1 million dollars), *appeal dismissed*, 101 S. Ct. 53 (1980); *Texas Landowners Rights Ass'n*, 453 F. Supp. at 1027-28 (administration and enforcement of measures regarding land management and use, flood control, and flood insurance); *Stiner v. Califano*, 438 F. Supp. 796, 798 (W.D. Okla. 1977) (three-judge court) (certain staffing ratios for day care centers); *Vermont v. Brinegar*, 379 F. Supp. 606 (D. Vt. 1974) (payment of just compensation for removal of billboards). Others have mandated the enactment or amendment of a state law, see *Steward Machine Co. v. Davis*, 301 U.S. 548, 574-76 (1937); *Florida v. Mathews*, 526 F.2d 319, 322 (5th Cir. 1976); *City of Macon v. Marshall*, 439 F. Supp. 1209, 1214 (M.D. Ga. 1977), or even a change in the state constitution, see *North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532, 535 (E.D.N.C. 1977) (three-judge court), *aff'd mem.*, 435 U.S. 962 (1978).

Appellants insist that section 1618 is nevertheless coercive because the effect of violating the condition—loss of Medicaid funds—is so drastic that the states have no choice but to comply. We are unpersuaded. The Supreme Court admonished in *Steward Machine Co.* that courts should attempt to avoid becoming entangled in ascertaining the point at which federal inducement to comply with a condition becomes compulsion. Justice Cardozo wrote in that case, "to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties." 301 U.S. at 589-90.

The wisdom of those words is illustrated by the determination that appellants would have us make. The courts are not suited to evaluating whether the states are faced here with an offer they cannot refuse or merely a hard choice. Even a rough assessment of the degree of temptation would require extensive and complex factual inquiries on a state-by-state basis.[21] We therefore follow the lead of other courts that have explicitly declined to enter this thicket when similar funding conditions have been at issue. For example, in *New Hampshire Dep't of Employment Security*, which was approved by this court in *County of Los Angeles v. Marshall*, see 631 F.2d at 769, the First Circuit held:

> We do not agree that the carrot has become a club because rewards for conforming have increased. It is not the size of the stake that controls, but the rules of the game.

616 F.2d at 246. *See also Texas Landowners Rights Ass'n*, 453 F. Supp. at 1030.

Moreover, appellants' characterization of the pass-through provision as coercive is belied by other cases approving equally persuasive conditions imposed on the use of federal funds. *See, e.g.*, *Lau*, 414 U.S. at 566 (loss of all federal financial assistance); *New Hampshire Dep't of Employment Security*, 616 F.2d at 246 (forty-million-dollar cost in tax credits to private employers); *Texas Landowners Rights Ass'n*, 453 F. Supp. at 1027-28 (ineligibility for both direct federal financial assistance for acquisition or construction purposes and for mortgage money from federally supervised private institutions); *North Carolina ex rel. Morrow*, 445 F. Supp. at 533 (failure to qualify for federal money under some forty federal health assistance programs); *Dupler v. City of Portland*, 421 F. Supp. 1314 (D. Me. 1976) (loss of food stamp funds). In addition, as noted above, Congress has previously enacted provisions that, like section 1618, condition receipt of Medicaid funds on compliance with certain requirements. *See* text preceding note 13 *supra*.

In sum, we find the pass-through condition consistent with the Tenth Amendment. Appellants' reliance on *National League of Cities* is misplaced because the provision at issue here is neither grounded on Congress' power under the commerce clause nor is it coercive. The impact of the pass-through provision on state activities does not render the condition invalid, and does not act to alter its essential nature as a permissible use of the congressional spending power to encourage state cooperation with federal plans.

IV. THE SCOPE OF THE PASS-THROUGH PROVISION

Appellants' final argument raises an issue of statutory construction: they contest the Secretary's interpretation of section 1618 as applying not only to state supplementary payments that increase the benefits supplied SSI recipients, but also to state supplementation in the sense of assistance to those who, because of their income level, are ineligible for SSI benefits. This second category of supplementation will be referred to here as "state-only" benefits. The district court found that this challenge was not ripe because at that time the Secretary had not yet promulgated final regulations implementing the pass-through provision. See 480 F. Supp. at 588. Since the decision below, however, those regulations have been adopted. See 45 Fed. Reg. 54,742, 54,743, 54,749 (1980) (to be codified at 20 C.F.R. § 416.2095(b)(3)). The question is therefore ripe for review, and we turn now to discuss the merits of appellants' claim.[22]

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[21] Arizona, for example, does not participate in the Medicaid program and therefore is presumably uninfluenced by the pass-through provision. See Brief for Appellees at 22.

The language of the pass-through provision is unambiguous in including both types of state supplementation. The state aid to which section 1618 applies consists of those "supplementary payments of the type described in section 1382e(a) of this title." Act § 1618(a), 42 U.S.C. § 1382g(a) (1976). The incorporated section, which is the portion of the Act that provides for state supplementation, defines state supplementary benefits as

> [a]ny cash payments which are made by a State (or political subdivision thereof) on a regular basis to individuals who are receiving benefits under this subchapter *or who would but for their income be eligible to receive benefits under this subchapter*, as assistance based on need in supplementation of such benefits.

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[22] The Secretary's regulations define the supplementary payment level that may not be reduced under § 1618 as the total state payment given an individual with no countable income in December, 1976. See 45 Fed. Reg. 54,742, 54,744, 54,750 (1980) (to be codified at 20 C.F.R. § 416.2097(a)). Those persons in the state-only category whose outside income does not increase may be entitled to an increase in the state supplementary payment as a result of the pass-through provision and its implementing regulations.

Suppose, for example, that A, an SSI beneficiary with no outside income, receives $150 from the federal government and $50 from the state, for a total income of $200. Assume also that B has an income of $165 and is therefore eligible only for state benefits; he would receive $35 from the state, for a total income, again, of $200. An SSI cost-of-living increase of $10 must be passed through to the recipients, so that A's income is now $210. If B's outside income does not change, the regulation's definition of supplementary payment level requires that the state increase its supplementary benefits to B by $10 so that he too has a total income of $210.

The Secretary considered this interpretation of "level" the one consistent with the legislative purpose of § 1618. The only other real alternative was to define "level" as the amount of state supplementation a particular individual receives. The Secretary rejected that construction for two reasons. It would mean, in the hypothetical above, that the state could not reduce its payment to A below $50 or its payment to B below $35. State benefits would then be frozen and could not reflect increases in a recipient's outside income. Moreover, individuals who became eligible for SSI after December, 1976, would not be protected by the pass-through provision. See 45 Fed. Reg. at 54,744-45.

Although § 1618 may require that a state increase payments to particular individuals, it does not as a result put an additional burden on the states. The Secretary has pointed out that the group of aid recipients represented by B in our hypothetical is not a large one. Typically, those in the state-only category are eligible for social security benefits under Title II of the Act. Those payments increase automatically in response to the cost of living. See *id.* at 54,745. If B's outside income of $165 rises because of an increase in social security benefits, the state's need to increase its aid to him would be correspondingly reduced. Moreover, the states' fiscal concerns are met by the pass-through section's provision that states are in compliance with its mandate if their total expenditures on supplementary benefits in any year are not less than the total spent during the preceding twelve months. See Act § 1618(b), 42 U.S.C. § 1382g(b) (1976); see *also* note 20 *supra*.

Id. § 1616(a), 42 U.S.C. § 1382e(a)(emphasis supplied).[23]

Appellants argue that, despite this language, section 1618 could not possibly have been meant to refer to the state-only cases because aid to those who are not SSI beneficiaries does not "supplement" any federal payment. But a state may supplement a federal assistance program in two ways—either by supplying aid to those who are ineligible for federal benefits[24] or by increasing the amount of the benefit given federal recipients. State-only benefits are also supplementary in the sense that they supplement recipients' income. Use of the term "supplementary" in the pass-through provision to refer to both types of state assistance is therefore not unreasonable.

Appellants next point to the absence of any indication in the legislative history that Congress intended the pass-through provision to apply to state-only cases. Section 1618 was offered as a floor amendment, and the only relevant legislative history therefore appears in the debates. It is true that this discussion focused on Congress' primary concern—that SSI recipients receive the benefit of cost-of-living increases. But courts need not find affirmative legislative history to support application of a statute according to its plain meaning. *See, e.g.*, *Caminetti v. United States*, 242 U.S. 470, 485-86, 490 (1917).

As the contemporaneous construction of the agency charged with the statute's enforcement, the Secretary's regulations are entitled to deference from this court. *See, e.g.*, *Udall v. Tallman*, 380 U.S. 1, 16 (1965); *Power Reactor Development Co. v. International Union of Electrical, Radio & Machine Workers*, 367 U.S. 396, 408 (1961). The Secretary's interpretation of the scope of the pass-through condition was based on the specific reference to state-only cases in section 1616(a) of the Act, the section quoted above that is incorporated in the pass-through provision,[25] and the relatively equal financial position of those who are eligible for both SSI benefits and a state supplement, on the one hand, and, on the other, those who receive only a state supplement. See 45 Fed. Reg. at 54,743.

As noted above, we approve the Secretary's reading of the language of section 1618. The second premise of the interpretation—that inclusion of the state-only cases is conducive to fair and effective implementation of the legislative intent—is precisely the type of determination best left to an agency with expertise in the field. Moreover, as appellees point out, the conclusion is reasonable that enforcement of the pass-through condition would be impossible if states were permitted to reduce the level of benefits given to those who receive only state supplements. A number of states dispense all supplementary benefits in a single program, without regard to whether or not the beneficiary also receives federal SSI benefits. If appellants' construction of section 1618 were correct, so that some recipients of state supplements—those also eligible for SSI—might suddenly begin receiving greater benefits than did others—those only eligible for state supplements—the Secretary would clearly be hampered in his ability to determine whether the state was complying with the pass-through provision. The confusion increases, along with the difficulty of enforcing section 1618, when one considers that the pool of persons eligible for SSI is constantly fluctuating. *Cf. North Carolina ex rel. Morrow* v. *Califano*, 445 F. Supp. 532, 536 (E.D.N.C. 1977) (three-judge court) (requiring certificates of need for all new health facilities—whether publicly or privately financed—held legitimate to prevent thwarting of congressional purpose), *aff'd mem.*, 435 U.S. 962 (1978).

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[23] The pass-through provision refers also to supplementation under Pub. L. No. 93-66, § 212, 87 Stat. 155 (1973), 42 U.S.C. § 1382 note (1976), which conditioned states' eligibility for Medicaid funds on their willingness to supplement SSI benefits to ensure that no recipient lost income as a result of the enactment of the SSI program. See note 4 *supra* & accompanying text. Like § 1616(a), quoted in text, § 212 applies to both types of supplementation. No other section of the Act differentiates between the two categories of state benefits.

[24] A provision in Title XIX illustrates this type of supplementation. Section 1902(a)(10)(C), 42 U.S.C. § 1396a(a)(10)(C)(1976), permits states to furnish supplemental Medicaid coverage to needy persons who would not otherwise receive Medicaid benefits because their income makes them ineligible for SSI or because they do not meet the state's eligibility criteria, see note 12 *supra*.

[25] The regulations are also premised on the inclusion of both types of state supplementation in the other provision referenced in the pass-through section, Pub. L. No. 93-66, § 212, 87 Stat. 155 (1973), 42 U.S.C. § 1382 note (1976). See 45 Fed. Reg. 54,742, 54,743 (1980); *see also* note 23 *supra*.

We therefore uphold the regulations' interpretation of section 1618: including state-only cases within its scope accords with the statutory language and is a reasonable exercise of the Secretary's authority to ensure fair and manageable administration of the provision.[26]

V. Conclusion

We find the pass-through provision of the Social Security Act, § 1618, 42 U.S.C. § 1382g (1976), a conventional and appropriate exercise of Congress' authority under the spending clause. The courts have long recognized the legitimacy of Congress' interest in ensuring the proper use of federal funds and have upheld a variety of terms attached to federal grant programs for that purpose. These conditions need not be restricted to those areas over which Congress has direct regulatory authority, and they need not be, as appellants urge, exactly correlated with the purpose of the funding program conditioned.

The pass-through provision was enacted for the permissible objective of guaranteeing that SSI cost-of-living increases approved by Congress benefit those whom they were designed to assist, rather than subsidize the states. The inclusion of the pass-through section in Title XIX, relating to Medicaid, rather than in Title XVI, dealing with SSI, does not render the condition unconstitutional. This court does not generally instruct Congress on drafting and structuring statutes, and, in any event, even appellants' rigid nexus standard is satisfied. The purpose of section 1618—to ensure a certain level of benefits to SSI recipients—is closely tied to the aims of the Medicaid program, which is a related component of Congress' attack on poverty. The legislative history of the Act and of its amendments, the evolution of the statute's current structure, and other exercises of Congress' power to condition receipt of federal funds all corroborate this link between the two programs.

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[26] Appellants urge that this court reject the Secretary's construction of section 1618 in order to avoid a difficult constitutional question, they maintain that the pass-through provision is even more suspect if it applies to state-only cases because of the greater attenuation between that type of state supplementation and the Medicaid program. We dismiss this argument for the reasons discussed above in part II(B), see *especially* note 10 *supra*. Moreover, we note that in some states recipients of state-only benefits are automatically eligible for Medicaid. See, e.g., Brief for Amicus Curiae at 8 (Alabama), *id.* at 17 (Oklahoma).

We likewise find the pass-through provision unobjectionable under the Tenth Amendment. The Supreme Court's opinion in *National League of Cities v. Usery*, 426 U.S. 833 (1976), is not controlling because it involved a statute that was based on Congress' power under the commerce clause and that compelled action by the states. Section 1618, in contrast, is premised on the spending power and is not coercive.

Finally, we reject appellants' challenge to the regulations interpreting the scope of the pass-through provision. The Secretary's determination that section 1618 applies to state supplementary payments in state-only cases is entitled to a good deal of deference from this court. In the absence of any controlling legislative history, the Secretary reasonably relied on the statutory language and his expert judgment of the prerequisites for fair and effective implementation of the pass-through provision.

Affirmed.

Part 1B
Rulings Based on Program Policy Statements

(To be Published as PPS-64) **SSR 82-30**
(Supersedes PPS-16 (SSR 78-8))

TITLES II AND XVI: RESPONSIBILITY FOR RESIDUAL FUNCTIONAL CAPACITY ASSESSMENTS

PURPOSE: To amplify the policy concerning the responsibility for assessing (or determining)[1] residual functional capacity (RFC) for cases decided in the Disability Determination Services (DDS) and at the hearing and Appeals Council (AC) levels, as delineated in the recodified regulations. This PPS supersedes Program Policy Directive (PPD) No. 16 (SSR 78-8), Residual Functional Capacity.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act, as amended, and Regulations No. 4, Subpart P, sections 404.1513, 404.1527, 404.1545, and 404.1546 and Regulations No. 16, Subpart I, sections 416.913, 416.927, 416.945, and 416.946.

PERTINENT HISTORY: PPD No. 16, published as SSR 78-8, provided that although the responsibility for the RFC assessment which is consistent with the evidence in file rests with the DDS staff physician, assessment of functional capacity should preferably be reported by a physician who has examined the claimant. Thus, the DDS staff physician was to provide an RFC assessment only when an assessment of functional capacity had not been provided by a medical source or when the DDS staff physician did not fully agree with the assessment provided by the source.

Experience with this method of documenting a claimant's RFC has shown that the RFC assessment used for disability determination purposes has frequently been incomplete in that it did not reflect an assessment of all the pertinent medical findings. Even where only one examining physician was involved, the physician ordinarily could not be expected to be fully aware of the program's criteria for making an RFC asessment.

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[1] In this context, the terms "assessing" and "determining" are interchangeable.

The disability regulations as recodified on August 20, 1980, set forth the responsibilities for assessing RFC. As stated in the regulations (sections 404.1546 ad 416.946), in cases where the DDS makes the determination, a DDS staff physician must assess RFC where it is required. Then, in determining disability, the RFC assessment must be considered in connection with the vocational criteria (sections 404.1560-404.1569 and 416.960-416.969). For cases decided at the hearing or AC levels, the responsibility for assessing RFC, as well as for deciding the issue of disability, rests with the administrative law judge (ALJ) or the AC.

It should be noted that under the regulations (sections 404.1513(c) and 416.913(c)), an important role of reporting medical sources is to provide a medical assessment of the claimant's ability to do work-related activities. However, this medical assessment (based on the physician's own observations and objective medical findings) is different from and is not intended to become the assessment of RFC (an administrative determination based upon all the relevant evidence). Medical assessments should be used by the DDS, the ALJ, or the AC, along with the other evidence, in making RFC assessments (as explained in sections 404.1513(d) and 416.913(d) of the regulations). The RFC assessment is then used by the DDS, the ALJ, or the AC in determining whether the individual can do past relevant work and, if not, whether the individual can do other work.

POLICY STATEMENT: In determining whether an individual is disabled, a sequential evaluation process is followed whereby current work activity, severity and duration of the impairment, and vocational factors are considered in that order. Before vocational factors can be considered, an RFC assessment is required. This assessment is based on all the relevant evidence, and it includes descriptions of the physical, mental, and sensory capacities and any environmental restrictions which may affect the individual's ability to function in a work setting.

In assessing RFC, the evidence provided by medical sources must be evaluated. This evidence should include the medical history, clinical findings, laboratory findings, diagnosis, treatment prescribed and response, prognosis, and a medical assessment describing ability to do work-related activities, as discussed in sections 404.1513(c) and 416.913(c). When more than one physician has provided medical information, the information provided by each source must be considered in the assessment of RFC. In making the RFC assessment, any medical assessments which are not supported by all of the medical evidence should be clearly rebutted.

The responsibility for assessing RFC in cases at the initial and reconsideration levels rests with a physician designated by the Secretary, ordinarily a DDS staff physician. In these cases, the DDS staff physician is responsible for assuring that the record contains the medical findings and other information necessary to support his or her RFC assessment. At the hearing and AC levels, the ALJ or AC, as appropriate, has the responsibility for making the RFC assessment, as well as the responsibility for assuring that the RFC assessment is supported by the medical findings and other information. When making the RFC assessment, the ALJ or AC will give probative weight to the DDS staff physician's RFC assessment. Although it is not binding, it is a medical judgment and constitutes expert opinion evidence. When additional evidence is received, the ALJ or AC, as appropriate, will determine what effect it has on the claimant's RFC.

If a further medical assessment of a claimant's ability to do work-related activities is needed, the ALJ or AC may request this medical assessment from a treating or examining physician through the DDS. An RFC assessment, as such, will not be requested from a treating or examining physician since the responsibility for assessing RFC is with the DDS staff physician, the ALJ, or the AC, as appropriate. Where the ALJ wishes to obtain an additional expert medical opinion to assist him or her in assessing RFC, the ALJ may call on the services of an Office of Hearings and Appeals' medical advisor. For cases before the AC, the AC may call on the services of its medical support staff.

EFFECTIVE DATE: These policies are effective for any case adjudicated on or after August 20, 1980, the date the final recodified regulations were published in the **Federal Register** at 45 FR 55566.

CROSS-REFERENCES: Program Operations Manual System (POMS) DI 2003, 2011, 2382.1, and 3027

(To be Published as PPS-65) **SSR 82-31**
(Supersedes PPS-46 (SSR 80-18))

TITLE XVI: SSI TREATMENT OF VETERANS ADMINISTRATION PAYMENTS TO SSI ELIGIBLES/FIDUCIARIES

This supersedes Program Policy Statement No. 46 (SSR No. 80-18), **Title XVI: SSI Treatment of Veterans Administration Payments to SSI Eligibles/Fiduciaries**

PURPOSE: To state supplemental security income (SSI) policy with respect to (1) Veterans Administration (VA) payments made to SSI eligibles where VA augments the payments because the recipient has dependents, and (2) VA payments made to fiduciaries.

CITATIONS (AUTHORITY): Section 1612(a)(2)(B) of the Social Security Act; Regulations No. 16, sections 416.1102 and 416.1121, 38 U.S.C. Veterans Benefits, Commissioner's Decision dated October 29, 1981.

PERTINENT HISTORY: 1. Social Security Administration (SSA) policy provides that VA disability compensation or pension benefits received by an eligible individual is unearned income to that individual (and is a resource if held to the next quarter). The income or resource is used in determining eligibility and amount of benefits under the SSI program.
Under VA law, a veteran or widow may receive an increased amount if there is a dependent. Before November 1981, SSA policy provided that the additional (augmented) portion of a VA benefit when included in the VA payment to the designated beneficiary (person to whom the check is actually made payable and thus, who may negotiate the check) was unearned income to that individual. There were continuing challenges in the courts on SSA's policy of counting the additional (augmented) payments as income to the designated beneficiary. In three such cases, the courts held (1) that the portion of the VA benefit computed on the basis of the existence and number of dependents could not be counted as income to the veteran as payee of the benefits and (2) to consider it as such would obviate Congressional intent which was to increase the basic VA benefit to cover additional expenses incurred for the care and maintenance of dependents. A reevaluation of the VA benefit structure by SSA's Office of General Counsel together with VA's legal counsel found support for excluding the additional (augmented) portion of the VA benefit as income to the designated beneficiary. A change in policy was approved by the Commissioner on October 29, 1981. Effective November 1981, SSA policy provides that the additional (augmented) portion of a VA benefit when included in the VA payment to the designated beneficiary is not income to that individual. The additional (augmented) portion is income to the dependent.
2. Benefits which are paid to an individual as a fiduciary (a party who receives and manages the benefits for another) are not available for the fiduciary's own use and, therefore, are not counted as unearned income of the fiduciary in the quarter of receipt or as a resource thereafter for the purpose of determining the fiduciary's eligibility for or amount of SSI benefits:
There are situations where a person may be receiving VA benefits as a beneficiary and also as a fiduciary for another person(s). For example: A World War II disabled veteran in receipt of his own VA compensation may also be in receipt of VA benefits in a separate check as a fiduciary on behalf of his incompetent Vietnam veteran son; a widow in receipt of her own VA pension may also be in receipt of VA benefits in a separate check as a fiduciary on behalf of her grandchild; or the child of a deceased veteran may be in receipt of dependents' education assistance, and also in receipt of dependent's indemnity compensation as a fiduciary on behalf of his or her brother or sister.

POLICY STATEMENT: 1. VA payments, **excluding** those augmented portions which are payable because of dependents, are income to the designated beneficiary for the purposes of determining eligibility and payment amount under the SSI program. The augmented portion is unearned income to the dependent.

2. Payments made by the VA to an individual in his or her capacity as fiduciary for another are not income or resources to the fiduciary for the purpose of determining his or her eligibility for or amount of benefits under the SSI program. For SSI purposes, such VA payments are income or resources of the individual for whom the VA payments are made.

EFFECTIVE DATE: The new policy in 1. is effective November 1981. The policy in 2. has been in effect for a number of years.

DOCUMENTATION: Appointment of a fiduciary and the amounts being paid must be documented. When a person is receiving payment as a fiduciary the check legend will show the name of the fiduciary followed by a phrase which indicates the fiduciary's relationship. The most common phrases are "wife of," "guardian of," and "custodian of the child-(ren) of." Other documentation may include a VA award letter which shows the same name and phraseology cited above or a copy of VA Form 27-4703, Fiduciary Agreement. The Veterans Administration issues separate checks for any benefits to which a payee is eligible in his or her own right.

CROSS REFERENCES: Program Operations Manual System SI 00810.120.A—00810.120.B.

Part II
Changes in Law and Regulations

SSR 82-II-I

LAW

The following public laws, enacted by Congress, are briefly explained below:

Public Law 97-86, Department of Defense Authorization Act, Signed on December 1, 1981

Title IX of the Act contains provisions to require draft registrants, at the time of registration, to furnish to Selective Service his Social Security number and other prescribed identifying information and permit the President to require the Secretary of HHS to furnish to Selective Service the name, date of birth, Social Security number and address of any individual required to register for the draft.

Public Law 97-123, Restoration of the Social Security Minimum Benefit and Other Changes, Signed on December 29, 1981

Restores the minimum benefit for current beneficiaries. Eliminates the benefit for new beneficiaries--people who reach age 62, die, or become disabled after 1981. Entitlement to the minimum benefit would be retained for those eligible after October 1981 and before November 1991 who are members of a religious order under a vow-of-poverty which elected to be covered under Social Security before December 29, 1981.

Permits interfund borrowing among the OASI, DI, and HI Trust Funds through December 31, 1982, with a provision for repayment with interest.

Extends the Social Security payroll tax to the first 6 months of sick pay including payments by insurance companies and under State temporary disability insurance laws, and the Railroad Temporary Disability Insurance program. Any portion of such sickness benefits paid for by employee contributions would not be covered.

Increase maximum penalties for the misuse of Social Security numbers.

Requires that the Secretary of HHS report within 90 days (by March 29, 1982) on the most effective system for improving SSA's current "report of death" procedures.

Requires that there be at least seven demonstration projects involving the use of AFDC recipients as home health aides, as authorized under the 1980 Omnibus Reconciliation Act.

Requires agencies of the U.S. Government or any State to disclose information necessary to carry out the provisions relating to the prohibition of payments to prisoners.

Public Law 97-127, Czechoslovakian Claims Settlement Act of 1981, Signed on December 29, 1981

Contains a Social Security-related provision to require the Secretary of State to conduct a review of the exchange of diplomatic notes between Czechoslovakia and the United States which provide the basis for the payment of U.S. Social Security benefits to Czechoslovakian citizens outside the U.S.

REGULATIONS SSR 82-II-II

The following amendments and additions under titles II and XVI of the Social Security Act have been published in the **Federal Register**:

A. REGULATIONS NO. 4—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE (20 CFR PART 404)

1. Subpart E—Amendments to this subpart were published in the **Federal Register** (47 FR 4985) on February 3, 1982.

These regulations require the Social Security Administration to reduce an individual's retroactive monthly Social Security benefits under certain conditions where the individual received SSI payments (including federally administered State supplementary payments) for the retroactive period.

B. REGULATIONS NO. 16—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED (20 CFR PART 416).

1. Subpart B—Amendments to this subpart were published in the **Federal Register** (47 FR 3099) on January 22, 1982.

These regulations revised and reorganized the general rules on eligibility under the SSI program. They describe who may get SSI benefits, how long a person's eligibility lasts, and the reasons why a person who would otherwise be eligible for SSI benefits might not get them.

2. Subpart K—Amendments to this subpart were published in the **Federal Register** (47 FR 4985) on February 3, 1982.

Refer to item A-1 for description of changes.

3. Subpart P—This new subpart was published in the **Federal Register** (47 FR 3106) on January 22, 1982.

This new subpart was established to state SSA's rules on residence and citizenship.

4. Subpart T—Amendments to this subpart were published in the **Federal Register** (46 FR 58664) on December 3, 1981.

This regulation affords States for which SSA administers State supplementation payments under the SSI program, the use of a regression formula in the computation of Federal fiscal liability (FFL) rates.

Part III
Items of General Interest

New and Revised Pamphlets

SSR 82-III-I

The following new and revised booklets and pamphlets explaining various aspects of the retirement, survivors, disability, and supplemental security income provisions of the Social Security Act, as amended, and of the black lung provisions, have become available for distribution. Single copies of these and other leaflets and booklets are available without cost at any Social Security office. Information on quantity purchases may be obtained from that office or from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

1. A Guide to Supplemental Security Income. SSA Publication No. 05-11015, July 1981.

A booklet designed to assist groups and organizations who have contact with potential or present SSI recipients. It describes the SSI program in detail.

2. Answers for Doctors. SSA Publication No. 05-10013, September 1981.

A booklet designed for doctors who may have patients who are missing out on benefits because they are unaware of the disability program.

3. If You Become Disabled. SSA Publication No. 05-10029, September 1981.

This booklet explains the requirements for disability benefits, how to apply, and how a decision is made. It also highlights some things a disabled person needs to know when a claim is approved and tells how a decision can be appealed if it is not approved.

4. History of Social Security. SSA Publication No. 05-10011, October 1981.

This leaflet contains a synopsis of the history of Social Security.

5. The Advantages of Social Security—A Message for Employees of Nonprofit Organizations. SSA Publication No. 05-10092, November 1981.

This leaflet is designed for organizations considering replacing Social Security with another pension or insurance plan. It explains the advantages of Social Security and presents some important points that should be considered before making a decision.

6. Farmers...How to Report Your Income for Social Security. SSA Publication No. 05-10025, December 1981.

This leaflet explains how farmers are to report their income from farm work for Social Security purposes.

7. Social Security Checks for Students 18 to 22. SSA Publication No. 05-10048, January 1982.

This leaflet explains how the legislation enacted in 1981 will gradually phase out Social Security student checks.

8. Reporting Changes That Affect Your Gold SSI Checks. SSA Publication No. 05-11053, January 1982.

This leaflet explains some of the things that must be reported and how to report them.

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Rulings

Social Security Rulings

On Federal Old-Age,
Survivors, Disability,
Supplemental Security Income,
and Black Lung Benefits

JULY 1982

SSR 82-32 to SSR 82-42

Department of Health
and Human Services
Social Security Administration
Office of Operational Policy and Procedure
SSA Pub No. 65-002
I. C. N. 958380

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reface

ocial Security Rulings (the SSR) is published under the authority of the ommissioner of Social Security and makes available to the public a eries of precedential decisions relating to Federal old-age, survivors, isability, supplemental security income, and black lung benefits pro- rams. All reference to individual or specific businesses involved have een avoided so as not to disclose confidential information, unless al- eady a matter of public record, as in a Federal court decision.

The SSR is based on case decisions, policy statements, decisions of he administrative law judges and the Appeals Council, opinions of the Office of the General Counsel, Commissioner's decisions, Federal court decisions, and other interpretations of the law and regulations. Once published, a ruling is binding on all components of the Social Security Administration in accordance with section 422.408 of Social Security Regulations No. 22 (20 CFR Part 422). Rulings do not have the force and effect of the law or regulations but are to be relied upon as precedents n determining other cases where the facts are basically the same. A rul- ng may be superseded, modified or revoked by later legislation, regulations, court decisions, or rulings.

Citations of a Social Security Ruling may be made by reference to the ruling number and the issue in which it appears. For example, ruling number one for 1980 would be cited as SSR 80-1 (Jan. 1980), or SSR 80-1 (C. E. 1980) if the annual Cumulative Edition has been published. Rulings based on court decisions are identified by a suffix "c" (such as SSR 80-1c), and rulings based on a decision of the Appeals Council of the Office of Hearings and Appeals are identified by the suffix "a" (such as SSR 80-1a).

All references to sections of law relate to sections of the Social Security Act, as amended, unless otherwise specified. All references to regulations, unless otherwise specified, are to Social Security Regulations Nos. 1, 4, 10, 16 and 22. These appear in title 20 of the Code of Federal Regulations as Parts 401, 404, 410, 416 and 422. The Code, revised as of April 1981, is available through the U. S. Government Printing Office at a subscription price of $525 per year (single copies cost $8). New and amended regulations are first printed in the *Federal Register;* individual copies may be purchased for $1.50.

The SSR is published quarterly—subscription price is $7.50 a year ($1.90 additional for foreign mailing); individual copies cost $2.25. An annual Cumulative Edition (formerly entitled the "Cumulative Bulletin") is published at the close of each calendar year reproducing all rulings published throughout the year which have not been superseded. The cumulatives for the two most recent years are available for sale from the U.S. Government Printing Office. Those currently available are the 1980 edition ($5.50) and the 1981 edition ($5.50). All other cumulative editions from 1960 on are available to the public free of charge upon request to the Social Security Administration, Office of Regulations, 6401 Security Blvd., Baltimore, Maryland 21235.

Other related publications available for sale through the U.S. Government Printing Office are:

1. *Compilation of the Social Security Laws*—a copy of the Social Security Act, as amended, is available in a paper cover edition entitled "The Social Security Act and Related Laws." It includes parts of the Internal Revenue Code and other laws pertinent to the Social Security Act. Inquiries made to the Superintendent of Documents, U.S. Government Printing Office, will supply the user the date of the current edition available and its cost.
2. *The Social Security Handbook*—the seventh edition, scheduled for publication in the Summer of 1982, reflects the provisions of the Social Security Act as amended through December 31, 1981. The Handbook is intended for the use of people who want a detailed explanation of the various programs administered by the Social Security Administration, how they operate, who is entitled to benefits, and how benefits may be obtained. Inquiries made to the Superintendent of Documents, U.S. Government Printing Office will supply the user with the cost of the Handbook.

These publications, including materials now being prepared or planned, when published, may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. A check or money order covering the cost of the publication should accompany the order.

Part IA
Rulings and Decisions

SSR 82-32

COMPUTATION AND PAYMENT OF BENEFITS WHERE AN ELIGIBLE INDIVIDUAL OR HIS ELIGIBLE SPOUSE IS IN A MEDICAID FACILITY (SSR 78-9 (Published as PPS-13) RESCINDED)

SSR 78-9 (C. E. 1978, p. 64) states the policy requiring separate computations of Federal Supplemental Security Income benefits for an eligible individual and his eligible spouse when one is in a hospital, skilled nursing facility, or intermediate care facility which is receiving payments under a State plan approved under title XIX. SSR 78-9 is rescinded without replacement because it duplicates section 1611(e)(1)(B)(ii) of the Social Security Act, §§416.430, 416.1147(e), and 416.2005(d) of Regulations No. 16, and the proposed retrospective monthly accounting modification to §416.414(b)(3) of Regulations No. 16.

SECTIONS 216(i) and 223(d) (42 U. S. C. 416(i) and 423(d)) DISABILITY INSURANCE BENEFITS—INABILITY TO PERFORM PREVIOUS WORK—ADMINISTRATIVE NOTICE UNDER THE MEDICAL-VOCATIONAL GUIDELINES OF THE EXISTENCE OF OTHER WORK—A RULING OF NONACQUIESCENCE

20 CFR 404.1560-404.1569 **SSR 82-33c**

Campbell v. Sec. of HHS, 665 F. 2d 48 (2nd Cir. 1981)*

The Social Security Administration (SSA) does not acquiesce in the court's decision.

The claimant, age 51, with a sixth grade education, applied for disability insurance benefits alleging total disability because of hypertension and a back condition caused by a herniated disc. The evidence of record showed that she could do "light work." SSA determined, under the medical-vocational guidelines (20 C. F. R. Subpart P, Appendix 2, Rule 202.10), that the claimant was "not disabled" and denied her application. Although SSA's decision did not identify specific "light work" jobs that the claimant could perform, when the guidelines were adopted, administrative notice had been taken of the existence of approximately 1,600 separate sedentary and light unskilled occupations in the national economy. When the claimant appealed to the U.S. District Court for the Eastern District of New York, the district court found the Secretary's decision was supported by substantial evidence. The claimant then appealed to the U.S. Court of Appeals for the Second Circuit. The Court of Appeals found that the evidence of record supported a finding that the claimant had the residual functional capacity to perform "light work." However, it found that she had been deprived of the opportunity to show she was not capable of performing the jobs administratively noticed by the guidelines. Accordingly, the Court concluded that SSA's finding that she was "not disabled" was not supported by substantial evidence and remanded the case to SSA "for further proceedings consistent with this opinion, including a listing of particular types of jobs suitable" to the claimant's capabilities.

SSA *holds* that, under the medical-vocational guidelines, the claimant had the capacity to perform any of approximately 1,600 separate sedentary and light unskilled occupations in the national economy and, therefore, was "not disabled." Since administrative notice had been taken of the existence of those jobs when the guidelines were adopted, it is unnecessary to identify examples of specific jobs suitable to the claimant's capabilities. Besides being contrary to the regulations, which promote the issuance of equitable, consistent, and understandable decisions in the administration of the disability program, a requirement of citing specific jobs would be administratively burdensome and costly, since expert vocational testimony would be required in each case to identify those jobs. SSA, under these regulations, had the authority to determine that the claimant was "not disabled" without identifying specific jobs the claimant had the capacity to perform.

Further, it is noted that the taking of administrative notice of the existence of 1,600 separate light and sedentary occupations under the medical-vocational guidelines has been upheld by Courts of Appeal in the First, Third, Fifth, Sixth, and Seventh Circuits. These courts have in effect supported SSA's position that the medical-vocational guidelines are within the Secretary's regulatory authority under section 205(a) of the Social Security Act, and since administrative notice of the existence of these jobs had been taken when the medical-vocational guidelines were adopted, it is not necessary for SSA to identify specific jobs which a claimant can perform. In addition, SSA's adherence to the *Campbell* decision in the Second Circuit would be inconsistent with uniform administration of the disability program, which is a national program, and would result in claimants being afforded different treatment because of where they reside.

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*On February 11, 1982, the Secretary's petition for rehearing of the Court of Appeals' decision of November 30, 1981, was denied. On April 26, 1982, the Solicitor General filed a petition for certiorari to the Supreme Court of the United States.

BONSAL, District Judge:**

Carmen Campbell appeals from a final judgment of the United States District Court for the Eastern District of New York (Costantino, J.), entered on April 30, 1981. The District Court granted the motion of the Secretary of the Department of Health and Human Services ("Secretary") for judgment on the pleadings and affirmed the Secretary's denial of insurance benefits to Ms. Campbell. We find that the record on which the Secretary's decision rests is inadequate in certain critical respects and accordingly we remand for further proceedings.

Background

On October 15, 1979 Carmen Campbell filed an application for disability insurance benefits with the Social Security Administration claiming total disability due to a back condition caused by a herniated disc and due to hypertension. On December 10, 1979 her application was denied. Ms. Campbell requested reconsideration which was again denied by notice dated March 21, 1980. On May 20, 1980 Ms. Campbell requested a *de novo* review of her application and on August 22, 1980 a hearing was held before an Administrative Law Judge ("ALJ") at which Ms. Campbell appeared *pro se*. In a decision dated September 26, 1980 the ALJ found that Ms. Campbell retained the capacity to do "light work" and that she was therefore "not disabled" within the meaning of the Social Security Act.

On October 31, 1980 Ms. Campbell sought review of the ALJ's decision by the Appeals Council. She submitted new medical evidence—a report by her treating physician, Dr. Lowenthal, which she asserted warranted a finding of disability by the Appeals Council. The Appeals Council made the report part of the record and denied her request for review.

On January 19, 1981 Ms. Campbell filed a *pro se* complaint seeking review of denial of benefits in the United States District Court for the Eastern District of New York (42 U. S. C. § 405(g)).

A hearing before the District Court was held on April 20, 1981 at which Ms. Campbell was represented by counsel. The district judge stated at the hearing that he had reviewed the record and suggested that in his opinion the Secretary's decision was supported by substantial evidence. The Secretary then moved for summary judgment and by Order dated April 23, 1981 Ms. Campbell's complaint was dismissed, from which Order she appeals.

**Sitting by designation as a Circuit Court Judge.

Facts

Ms. Campbell, aged 51 at the time she filed her application, was born in Panama where she completed a sixth grade education. Spanish is her first language but she has a "fair" knowledge of English. Ms. Campbell was employed as a hotel maid. Her duties included making beds, dusting, vacuuming and pushing "trucks" which carried her equipment. Between 1971 and 1973 she also worked as a seamstress in the hotel, and in 1973 she injured her back while moving a large laundry truck. In 1975 her doctor informed her that she had a slipped disc. However, she continued working until December of 1978. In January of 1979 Ms. Campbell underwent a laminectomy to remove a herniated disc. She was discharged within two weeks.

The ALJ considered the medical and hospital records and the reports of Drs. Khatib and Lowenthal. Dr. Khatib diagnosed Ms. Campbell's herniated disc, performed the operation and saw her during several follow-up visits. In May of 1979 Dr. Khatib reported that she could return to work in June so long as she did not lift heavy objects or do "strenuous work." In July Dr. Khatib reported that she could return to "light duty work" and in November of 1980 reported that she "is disabled from doing her regular work and should avoid lifting heavy objects and strenuous work."

Ms. Campbell saw Dr. Lowenthal at the request of the State of New York Workers' Compensation Board from February of 1980 through the spring and summer. In August of 1980 Dr. Lowenthal filled out a questionnaire stating that she could continuously stand for 30 minutes, sit for 30 minutes, and alternately stand or sit at one time for one hour; that due to severe pain she must lie down during the day and that she could lift or carry weights of "up to ten pounds."

The ALJ considered Ms. Campbell's age, education, past work experience and the medical evidence. He found that Ms. Campbell was no longer able to work as a hotel maid but that she could do "light work." He concluded that since she could do "light work," Ms. Campbell was not under a "disability" as defined by the Act. (42 U. S. C. § 423(d)(1)).

Discussion

Section 423 (d) (1) (A) provides that the term "disability" means:

> inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; . . .

42 U. S. C. § 423(d) (1) (A) (1974).

For the purposes of Section 423(d) (1) (A), the individual must be [able]

> . . . not only to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the imme-

> diate area in which he lives, or whether he would be hired if he applied for work . . . .

42 U. S. C. § 423(d)(2)(A)(1974).

The initial burden of proving that a disability exists rests upon the claimant. 42 U. S. C. § 423(d)(5)(1977); *Parker v. Harris*, 626 F. 2d 225, 231 (2d Cir. 1980). In this case there is no dispute that this burden was met because the ALJ made a specific finding that Ms. Campbell's condition prevented her return to her past work.

Thereupon,

> . . . the burden shifts to the Secretary, who must produce evidence to show the existence of alternative substantial gainful work which exists in the national economy and which the claimant could perform, considering not only his physical capability, but as well his age, his education, his experience and his training. *Parker v. Harris*, 626 F. 2d at 321 (citations omitted).

Here the Secretary must show:

> First, . . . that the claimant's impairment is of a kind that still permits certain types of activity, such as lifting or walking, necessary for other occupations, and that the claimant's experience involves skills transferable to other work. Second, the Secretary must present evidence showing the existence of specific types of jobs, available in the national economy, suitable for a claimant with these capabilities and skills. See, *e.g., Bastien v. Califano,* 572 F. 2d 908, 912-13 (2d Cir. 1978). *Decker v. Harris,* 647 F. 2d 291, 294 (2d Cir. 1981).

In order to promote a more efficient analysis of relevant factors and to promote consistency in decision by the Secretary in the adjudication of disability claims, the Social Security Administration adopted new regulations which became effective on February 26, 1979. 20 C. F. R. §§ 404.1501-.1598.

Under the new regulations, once it is determined that the claimant cannot perform her past work, the Secretary must show what the claimant's "residual functional capacity" is. Here the ALJ found that Ms. Campbell was capable of performing "light work." "Light work" is defined by the regulations as follows:

> (b) *Light work.* Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. *Id.* § 404.1567.

The record as a whole supports the ALJ's finding that Ms. Campbell had the "residual functional capacity" to perform "light work."

[*Evaluation Under Medical-Vocational Guidelines*]

Having determined that Ms. Campbell had the capacity to perform "light work," the regulations require the Secretary to show the availability of jobs in the national economy "suitable for a claimant with these capabilities and skills." *Decker v. Harris*, 647 F. 2d at 294. To assist the Secretary in making this showing, the "medical-vocational guidelines" were adopted. See 20 C. F. R. Subpart P, Appendix 2. In Ms. Campbell's case, the ALJ relied on rule 202.10 of the guidelines which provides that a person who is "closely approaching advanced age," with a limited education, and whose prior work experience is unskilled is "not disabled." The Secretary contends that the ALJ is not required to identify specific jobs because their existence has already been administratively noticed through the adoption of the guidelines.[3]

Before and after the adoption of the guidelines this circuit has consistently required that "the Secretary identify specific alternative occupations available in the national economy that would be suitable for the claimant" and that "these jobs be supported by 'a job description clarifying the nature of the job, [and] demonstrating that the job does not require' exertion or skills not possessed by the claimant. *Bastien* v. *Califano*, supra, 572 F. 2d at 912-13." *Decker* v. *Harris*, 647 F. 2d at 298. See also *Parker* v. *Harris*, 626 F. 2d at 233-34. In the past, this has been done largely through the use of vocational testimony to establish that there are specific jobs suitable to the claimant's capabilities.

The central issue in this case is whether the guidelines provide adequate evidence of a claimant's ability to perform a specific alternative occupation. This circuit recently examined the conflict between the guidelines and prior case law in *Decker v. Harris*, *supra*. While the court did not have to resolve the conflict in that case because the issue was not "squarely presented" on the facts, the court did reaffirm the need for a specific showing of suitable alternative jobs. The court said:

> We believe that the essential concern . . . is that if the Secretary chooses to proceed without expert testimony by taking administrative notice, the Secretary must provide a similar degree of specificity to achieve the underlying objectives of procedural fairness to the claimant and preservation of an ade-

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Footnotes 1 and 2 omitted (ED).

[3] As the introduction to the guidelines explains:

"(b) the existence of jobs in the national economy is reflected in the 'Decisions' shown in the rules; i. e., in promulgating the rules, administrative notice has been taken of the numbers of unskilled jobs that exist throughout the national economy at the various functional levels (sedentary, light, medium, heavy and very heavy) as supported by the 'Dictionary of Occupational Titles' and the 'Occupational Handbook', published by the Department of Labor; the 'County Business Patterns' and 'Census Surveys' published by the Bureau of Census; and occupational surveys of light and sedentary jobs prepared for the Social Security Administration by various State employment agencies." 20 C. F. R., Subpart P, Appendix 2, § 200.00(b).

> quate record for review. The key consideration in the administrative proceeding must be that the claimant be given adequate opportunity to challenge the suitability or availability of the jobs noticed. *Id.* at 298.

Now that the issue is "squarely presented," our major concern is that the claimant be given adequate notice of the nature and demands of the types of jobs allegedly available. Absent sufficient notice, the claimant is deprived of any real chance to present evidence showing that she cannot in fact perform the types of jobs that are administratively noticed by the guidelines. This is particularly true in Ms. Campbell's case where the ALJ gave no indication of any specific "light work" jobs that she was capable of performing but relied on the guidelines which take notice of approximately 1,600 types of "light work" jobs available in the national economy. 20 C. F. R. Subpart P, Appendix 2, § 202.00. If there are so many types of jobs available, it would not be too great a burden for the secretary or the ALJ to specify a few suitable alternative available types of jobs so that a claimant is given an opportunity to show that she is incapable of performing those jobs. Moreover, we stress that the jobs should be specified at the hearing so that the claimant has a chance to put evidence into the record on that issue. In Ms. Campbell's case she was not informed of the Secretary's position and the ALJ's findings until she received his decision, when it was too late for her to rebut any finding of available "light work" jobs. In failing to show suitable available alternative jobs for Ms. Campbell, the Secretary's finding of "not disabled" is not supported by substantial evidence.

Accordingly, we remand this case to the Secretary for further proceedings consistent with this opinion, including a listing of particular types of jobs suitable to the capabilities of Ms. Campbell.

SECTIONS 216(i) and 223(d) (42 U.S.C. 416(i) and 423(d)) DISABILITY INSURANCE BENEFITS—INABILITY TO PERFORM PREVIOUS WORK—ADMINISTRATIVE NOTICE OF THE EXISTENCE OF OTHER WORK

20 CFR 404.1503-404.1513* **SSR 82-34c**

Boyce v. Harris, 492 F. SUPP 751 (USDC, South Carolina 1980), **New v. Harris**, 505 F. SUPP 721 (USDC, S. D. Ohio, E. D. 1980), and **Turner v. Harris**, USDC, C.D. California, Civ. No. CV80-1117-LTL(P) (1/8/81)

The plaintiff, in *Boyce*, who was born in 1943 and has a ninth-grade education, applied for disability insurance benefits in March 1978, alleging that he has been unable to work since January 1978. Although the plaintiff has had three back operations and was unable to perform his former job, the evidence of record showed that the plaintiff had recovered sufficiently by June 1978 to perform light work. When the Social Security Administration (SSA) determined, under its vocational factors regulations, that the plaintiff was not disabled and denied his application, the plaintiff appealed. Although the plaintiff's impairment prevented him from returning to his former job, the court found that the vocational factors regulations permitted SSA to consider the plaintiff's age, education, work experience, and residual functional capacity in determining whether he could perform other work. As part of the process of adopting these regulations, SSA had taked administrative notice of the existence of numerous unskilled light and sedentary occupations in the national economy. On that basis, SSA concluded that the plaintiff could perform any of 1600 unskilled light and sedentary occupations in the national economy. In affirming SSA's determination that the plaintiff was not disabled, the court upheld the vocational factors regulations and *held* that SSA had complied with them. The court *further held* that SSA's application of the vocational factors regulations to the facts in the plaintiff's case supported its decision that the plaintiff could do various unskilled entry-level jobs and that because this decision was supported by substantial evidence, testimony from a vocational expert was unnecessary.

(Similar conclusions were reached in *New v. Harris*, 505 F. SUPP 721 (USDC, S.D. Ohio, E.D. 1980) and in *Turner v. Harris*, USDC, C.D. California, Civ. No. CV80-1117-LTL(P) (1/8/81), and this ruling is based on those two decisions as well as the *Boyce* case. The *New* and *Turner* decisions appear immediately after the *Boyce* decision. Ed.)

CHAPMAN, District Judge:

The plaintiff brought this action pursuant to Section 205(g) of the Social Security Act, as amended (42 U.S.C. 405(g)), to obtain judicial review of a final decision of the Secretary of Health, Education, and Welfare, denying his claim for disability insurance benefits under Title II of the Social Security Act.

The plaintiff filed an application for a period of disability and for disability insurance benefits on March 31, 1978, alleging that he became unable to work on January 7, 1978. The application was denied initially and on reconsideration by the Social Security Administration. On February 15, 1979, the plaintiff requested a hearing. The administrative law judge, before whom the plaintiff, his counsel and a witness appeared, considered the case *de novo*, and on May 29, 1979, found that the plaintiff was not under a disability as defined in the Social Security Act, as amended. The administrative law judge's finding became the final decision of the Secretary of Health, Education and Welfare, when it was approved by the Appeals Council on August 23, 1979.

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*The regulations used to make disability determinations under titles II and XVI of the Social Security Act were recodified effective August 20, 1980. See 45 FR 55566-55634 (1980) (recodified in 20 CFR 404.1501-404.1598 and 20 CFR 416.901-416.996). The regulations cited in this ruling have been renumbered and rewritten as part of the recodification, but not substantively changed. See §404.1560-§404.1569 and Rule 202.10, Appendix 2, Subpart P of Regulations No. 4.

The only issue before the Court is whether the final decision of the Secretary is supported by substantial evidence. Substantial evidence is defined as that evidence which a reasonable mind would accept to support a particular conclusion. It is more than a mere scintilla but may be somewhat less than a preponderance. *Laws v. Celebrezze*, 368 F.2d 640 (4th Cir. 1966); *Thomas v. Celebrezze*, 331 F.2d 541 (4th Cir. 1964).

"Disability" is defined by the Social Security Act as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment . . . which has lasted or can be expected to last for a continuous period of not less than 12 months," 42 U.S.C. 423(d)(1)(A).

The Court in *Blalock v. Richardson*, 483 F.2d 773, 775 (4th Cir. 1972), stated:

> The scope of judicial review by the federal courts is specific and narrow under §205(g) of the Act. That section provides that '. . . the findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive . . .' The fact that the record as a whole might support an inconsistent conclusion is immaterial, for the language of §205(g) precludes a *de novo* judicial proceeding and requires that the court uphold the Secretary's decision even should the court disagree with such decision as long as it is supported by 'substantial evidence.'

Effective February 26, 1979, the Secretary has promulgated new regulations, 20 C.F.R. §§ 404.1502 to 1513 and Subpart P, App. 2 (1979), to consolidate and elaborate upon long standing medical-vocational evaluation policies for adjudicating disability claims in which an individual's age, education, and work experience must be considered in addition to the medical experience. 43 Fed. Reg. 55,349 (1978). The new regulations define each factor to be considered in determining whether disability exists. 20 C.F.R. §§ 404.1505 to 1511. More importantly, they direct a finding of disability or no disability where the findings of fact in a particular case coincide with the criteria established in the rules and tables of Subpart P, Appendix 2. 20 C.F.R. § 404.1513.

It is the duty of this Court to give careful scrutiny to the whole record to assure that there is a sound foundation for the Secretary's findings, and that his conclusion is rational. *Thomas v. Celebrezze*, 331 F.2d 541, 543 (4th Cir. 1964).

This Court is empowered to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing.

This gentleman was born on March 23, 1943, and was 36 years old at the time of his hearing. He is married with two children, ages 15 and 18, has a ninth-grade education and has worked in textiles primarily as a loom fixer. The plaintiff testified that he had to quit work because of severe pain and that he has trouble walking. He was receiving benefits from workmen's compensation for an injury he received in 1971 when he slipped on a patch of oil. He has not worked since 1978.

The Secretary has adopted the findings of the administrative law judge, who concluded:

* * * *

> 4. That the claimant has had 3 back operations, the most recent in January 1978 when a laminectomy and spinal fusion was performed, and post-operatively had recovered sufficiently by June 1978 to perform light work.
>
> 5. That the medical evidence does not document impairments of incapacitating proportions, i.e., ones which would produce pain of such intensity that the ordinary physical activity necessary to perform light work would be impossible or contraindicated.
>
> 6. That the evidence in the record fails to show that the claimant has an anatomical or physiological condition which was demonstrated by reports of physicians that were supported by medically acceptable clinical and laboratory diagnostic procedures such as show the claimant to be under a disability within the meaning of the Social Security Act.
>
> 7. That the evidence does not demonstrate that the claimant at any time through the date of this decision was unable to engage in any substantial gainful activity because of a medically determinable impairment or combination of impairments which had lasted or can be expected to last for 12 months or end in death.
>
> 8. That the claimant is unable to perform his former job of loom fixer in the textile industry.
>
> 9. That the claimant has the residual functional capacity for light work as defined by Section 404.1510(c) of Subpart P, Regulations No. 4.
>
> 10. That the claimant is "a younger individual", as defined by Section 404.1506(b) of Subpart P, Regulations No. 4.
>
> 11. That the claimant has an 8th grade education, which is defined as a "limited education" by Section 404.1507(b) of Subpart P, Regulations No. 4.

> 12. That the claimant is able to perform "unskilled" work, as defined by Section 404.1511(b) of Subpart P, Regulations No. 4.
>
> 13. That the claimant's job as a loom fixer imparted to him no skills that are readily transferable to jobs other than those that he previously held, as provided in Regulation 404.1511(e) of Subpart P, Regulations No. 4.
>
> 14. That Section 404.1513 and Rule 202.17, Table No. 2 of Appendix 2, Subpart P, Regulations No. 4, requires that the claimant, considering his maximum sustained work capacity, age, education, and work experience, be found "not disabled."

On June 6, 1974, the plaintiff underwent surgery for a herniated nucleus pulposus.[1] A partial hemilaminectomy[2] was performed at L-4. The plaintiff continued to complain of pain following the surgery and a lumbar myelogram performed by Dr. Max Kent (an orthopedic surgeon) on November 25, 1977, revealed that he was suffering from a herniated disc. On January 14, 1978, Dr. Kent performed a lumbar laminectomy and a bilateral lateral transverse process spinal fusion at L-4 to S-1. Herniated discs at L-4, L-5 and L-5, S-1 were removed.

The plaintiff's postoperative course was satisfactory. On January 31, 1978, Dr. Kent reported that the plaintiff was having no further pain in his legs but was experiencing minimal back pain. On March 31, 1978, Dr. Kent reported that the plaintiff was still having some discomfort in his back but that his legs were markedly improved.

On June 15, 1978, Dr. William B. Jones, an orthopedic surgeon, examined the plaintiff and found that he was not totally disabled and he would be better off performing a variety of gainful employment tasks rather than sitting home. It was Dr. Jones' opinion that the plaintiff was disabled from working as a loom fixer, but could perform stand-up jobs such as a service station attendant or bench work standing up and lifting weights of 25 to 30 pounds.

The determination that the plaintiff was unable to return to his customary work shifted to the Secretary the burden of establishing that the plaintiff had sufficient capacity to engage in a specific job which exists in the national economy. *Taylor v. Weinberger*, 512 F.2d 664 (4th Cir. 1975).

In *Taylor v. Weinberger*, *supra*, the Fourth Circuit Court of Appeals expressly rejected the contention that the Secretary may establish vocational ability solely by administrate notice or medical evidence.

* * * *

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[1] Nucleus pulposus is defined as "a semifluid mass of fine white and elastic fibers that forms the central portion of an intervertebral disk". *Dorland's Illustrated Medical Dictionary*, 25th Ed., 1974, p. 1064.

[2] Removal of the vertebral laminae on one side only. *Dorland's Illustrated Medical Dictionary*, 25th Ed., 1974, p. 693.

There is indication in the testimony that the plaintiff's back was healing slowly, but the same doctor indicated that the pain resulting from this condition was minimal and that neither the pain nor the back condition prevented plaintiff from engaging in substantial gainful activity.

The underlying rationale of *Taylor v. Weinberger* seems to have been made obsolete by the new Vocational Factors Regulations 20 C.F.R. §§404.1503-404.1513. It is the obvious purpose of these regulations to allow the Secretary to make findings of disability or lack of disability based on certain specific criteria including age, educational level, degrees of work experience and residual functional capacities. One purpose of these regulations is to allow the Secretary to decide cases more promptly and without the necessity of hearing from a vocational expert in every case in which the claimant cannot return to former employment because of physical limitations.

In adopting these regulations the Secretary has taken notice that there are at least 200 separate unskilled sedentary occupations, some 1600 unskilled light and sedentary occupations and some 2500 unskilled medium, light and sedentary occupations in the national economy. The words "sedentary", "light" and "medium" are specifically defined in 20 C.F.R. §404.1510. The physical exertion required for these jobs, whether or not the employee must walk, stand or remain seated and other facts relating to the employment have been taken into consideration in arriving at the new regulations. The record reflects that the Secretary has complied with the regulations and made the necessary findings to support his decision that the plaintiff was able to perform various unskilled, entry-level jobs. This decision is supported by substantial evidence and, therefore, the decision of the Secretary must be affirmed and the Clerk of Court shall enter judgment in favor of the defendant.

AND IT IS SO ORDERED.

DUNCAN, District Judge.

Plaintiff Leonard New brings this action under 42 U.S.C. § 405(g) and § 1383(c)(3) for review of a final decision of the Secretary of Health, Education and Welfare (now Secretary of Health and Human Services) denying his applications for social security disability insurance and supplemental security income benefits. This matter is before the Court on the cross-motions of the parties for summary judgment.

Plaintiff filed his application for disability insurance benefits on February 23, 1978 alleging that he became disabled in 1971, at age 35, by black lung trouble, ulcers, and a nervous condition. Plaintiff filed his application for supplemental security income benefits on March 2, 1978. Both applications were denied initially and upon reconsideration by the Bureau of Disability Insurance of the Social Security Administration. Plaintiff requested a hearing before an administrative law judge.

On June 14, 1979 plaintiff, who was not represented by counsel, appeared and testified at the hearing. On July 23, 1979 the administrative law judge issued a decision finding that Mr. New is not disabled within the meaning of the Act. On January 15, 1980 the Appeals Council denied plaintiff's request for review and adopted the administrative law judge's decision as the final decision of the Secretary of Health, Education and Welfare.

The facts of record are fully and fairly set out in the administrative law judge's July 23, 1979 decision which is incorporated herein by reference.

Plaintiff Leonard New was born June 23, 1936. He has a seventh grade education. He has worked as a construction laborer, bulldozer operator, mechanic, service station atendant, and loader operator.

Plaintiff testified that his most serious problem is with his lungs. He said that Dr. Jindra told him that he had only 45 per cent air capacity in his left lung and that he was permanently and totally disabled for the rest of his life because the condition would not improve and there was nothing he could do for it. Plaintiff said that he has a strangling sensation in his lungs and a cough.

Mr. New also testified that he has constant pain and hurt in his back and legs. He said that he gets muscle spasms. He takes Talwin as needed for the pain because, he testified, "I don't like to fool with drugs." He takes maybe one or two Talwin tablets then goes two or three days without any pain medication, "and then I'll start hurting real bad again, and then I'll take another one." He said that the Talwin "eases things off . . . it still hurts, but it don't hurt as bad."

Plaintiff testified that he had suffered from an ulcer condition in the past. He no longer takes prescribed medication for his ulcers. He does sometimes take Tums. Plaintiff has some loss of hearing in his right ear and fluid in the ear. But he no longer takes the prescribed drops for the ear because when they get on his neck they burn. Plaintiff testified that he is bothered by nerves. He takes one or two Valium, 5 mg. a day. They calm him down and relax him (which helps with the pain).

Plaintiff testified that during a typical day he gets up at dawn and dresses. He watches T.V., then goes outside and sits around. He drives to the store once a day and visits a neighbor. He said that he doesn't help his wife much around the house, except to pour gasoline out of the truck for the lawnmower and to sometimes screw a loose knob back on a cabinet or perform a similar chore.

Plaintiff estimated that he could sit only about 30 minutes then his legs would get numb and his back would hurt so much that he would have to get up. He thought he could stand for only about 10 minutes because his legs start hurting, and they shake. He believed that he could walk about 200 feet, then he would be completely out of breath and his legs would be tired. When going up and down stairs his knees buckle. Plaintiff estimated he could lift 25 to 30 pounds.

On September 15, 1978 Dr. Louis J. Jindra reported that he had first examined Mr. New on May 10, 1978. Plaintiff suffers from dyspnea. Dr. Jindra diagnosed chronic bronchitis, emphysema, and exogenous obesity. On March 28, 1978 Dr. R.C. Estrada examined plaintiff at the request of the Secretary. He reported that he smoked one to two packs of cigarettes a day. He was 70½ inches tall and weighed 228 pounds. He had an increased AP diameter of his chest. On examination, Dr. Estrada heard occasional rhonchi, but no rales. An x-ray was interpreted to show no active pulmonary infiltrate. There was evidence of chronic lung disease and fibrotic changes and fibronodular old granulomatous lesions of both lung fields. Pulmonary function studies reported plaintiff's height as 70½ inches, his FEV_1 as 2.13 liters, and his MVV as 103 liters. Dr. Estrada stated that these values indicated the presence of a combined restrictive and obstructive pulmonary disease.

During an April 6, 1979 hospitalization, plaintiff reported a history of 35 years of smoking two packs of cigarettes a day. He was also treated for tuberculosis in 1973. The hospital report states that plaintiff becomes short of breath on exertion after walking 100 yards. On physical examination he had a mildly increased AP chest diameter. Diffuse sibulant and sonerous rhonchi were heard on ausculation together with a prolonged expiratory time on the fourth expiration.

Although plaintiff complains of back and leg pain, the medical evidence of record indicates that he suffers from lumbosacral strain. Dr. Estrada reported that a neurological examination was negative. There was no evidence of muscle spasm. Straight leg raising was negative. Plaintiff had a reasonably good range of motion in his lumbar spine. He was able to walk on his heels and toes. Plaintiff's treating orthopedic physician, Dr. Richard M. Ward, had plaintiff hospitalized on April 6, 1979 at the Riverside Methodist Hospital for evaluation of his low back. An examination failed to disclose any objective evidence of a serious back disorder. The height and alignment of his lumbar vertebral bodies was normal. The posterior elements were normal. On examination, there was only very mild tenderness to palpation over the lumbosacral spine area at L-3 to L-5. There was no tenderness of the paraspinal muscles. Dr. Ward ruled out a herniated nucleus pulposus.

[1] This Court's review of the decision of the Secretary is limited to a determination of whether her findings are supported by substantial evidence. 42 U.S.C. § 405(g). *Richardson v. Perales*, 402 U.S. 389, 401, 91 S.Ct. 1420, 1427, 28 L.Ed.2d 842 (1971); *LeMaster v. Weinberger*, 533 F.2d 337, 339 (6th Cir. 1976). It is not the Court's function to resolve conflicts in the evidence or to determine issues of credibility. This is solely the province of the Secretary. *Wokojance v. Weinberger*, 513 F.2d 210 (6th Cir. 1975). Pain alone may be disabling, but the Secretary is not required to fully credit a claimant's subjective complaints of pain and discomfort if there is not "an underlying medical basis" for them. *McCann v. Califano*, 621 F.2d 829, 832 (6th Cir. 1980); *Hephner v. Mathews*, 574 F.2d 359, 361-362 (6th Cir. 1978).

Plaintiff moves for summary judgment and remand on the grounds that (1) the administrative law judge erred in his evaluation of plaintiff's nervousness; (2) the administrative law judge erred in his finding that plaintiff's lack of regular usage of pain medication demonstrated that his pain was not disabling; and (3) the Secretary failed to meet his burden of demonstrating that plaintiff can perform substantial gainful work in his lessened capacity.

The administrative law judge's decision notes that Dr. Jindra diagnosed only chronic bronchitis, emphysema, and exogenous obesity and did not mention plaintiff's nervousness. The questionnaire sent to Dr. Jindra did not specifically ask him for information concerning plaintiff's psychiatric condition. The administrative law judge also noted that Dr. Ward, plaintiff's treating orthopedic surgeon, stated that Mr. New had a good ability to relate to others and to take care of his personal needs, and that there had been no change in his interests, habits, or impairment to his recent or remote memory.

Plaintiff contends that the administrative law judge should have asked Dr. Jindra to specifically comment on Mr. New's nervousness because he testified at the hearing before the administrative law judge that he had discussed his nervous condition with Dr. Jindra.

Dr. Jindra did indicate his diagnosis of plaintiff in his report to the Secretary. Plaintiff has the burden of presenting evidence of disability. Although plaintiff was not represented by counsel before the administrative law judge, he was represented by counsel on the appeal to the Appeals Council. If Dr. Jindra had inadvertently failed to include information concerning plaintiff's nervous condition, then counsel could have brought that information to the attention of the Appeals Council.

[2] Moreover, there was considerable other evidence in the record that plaintiff's nervous condition does not amount to a severely limiting impairment. Daily he is able to go to the store and visit with a neighbor. There do not appear to be any severe restrictions in his daily activities which are the result of a mental or emotional condition. Under these circumstances, the administrative law judge did not err in his assessment of Mr. New's nervous condition.

[3] The administrative law judge discounted plaintiff's subjective complaints of severe, disabling pain:

> [T]he claimant's complaints of constant severe pain are not accepted as credible in view of the apparent lack of regular usage of pain medication and the claimant's testimony as to his daily activities.

Plaintiff asserts that his daily activities are limited, and that he does not use drugs because of his fear of over-medication.

Talwin is a non-narcotic, non-prescription analgesic. Plaintiff testified that it gave him relief, but that he nonetheless did not take Talwin daily despite his testimony that he was in consant, severe pain. Under these circumstances, the administrative law judge's comment on his sporadic pain medication was not error.

Plaintiff did testify, overall, that his daily activities were limited. Nonetheless, he did admit to quite a bit of daily activity. He drives to the store once a day, and he drives to visit a neighbor once a day. Although he watches some television, he normally goes outside and occupies himself there for some portion of each day. The administrative law judge had the right to consider plaintiff's account of his daily activities in reaching his determination on the issue of credibility.

Finally, plaintiff contends that there was not substantial evidence in the record for the administrative law judge's assertion that plaintiff has the physical capacity to perform light work and that his reliance on the Medical-Vocational Guidelines to demonstrate that there are jobs plaintiff can perform was erroneous.

[4] Plaintiff is unable to perform his previous jobs; therefore, the Secretary had the burden of demonstrating that he could perform substantial gainful work in his lessened capacity. *Allen v. Califano*, 613 F.2d 139, 145 (6th Cir. 1980); *Hephner v. Mathews*, 574 F.2d 359, 362 (6th Cir. 1978).

Plaintiff clearly is suffering from chronic obstructive pulmonary disease and some low back pain resulting from lumbosacral strain. In addition, he has some hearing loss and fluid in his right ear which does not preclude substantial gainful activity. He was previously treated for ulcers, but the ulcers are presently not an impairing condition. He also suffers from some nervousness which is relieved, to some significant degree, by Valium, 5 mg. The administrative law judge had the difficult job of determining whether these combined impairments preclude plaintiff from engaging in all substantial gainful activity.

Plaintiff himself testified that his most serious disability was his pulmonary disease. Although the condition certainly does limit his ability to perform substantial gainful activity, there are no medical reports of record indicating that the condition is totally disabling. To be disabled by a chronic obstructive airway disease on the basis of pulmonary function studies values alone, a person of plaintiff's height would have to have an FEV$_1$ equal to or less than 1.4 liters and an MVV equal to or less than 45 liters. Plaintiff's actual pulmonary function studies values are greatly in excess of these. Section 3.02, Subpart P, Appendix 1—Listing of Impairments.

[5] Similarly, although plaintiff testified that he has severely disabling low back pain, complete tests rule out any disc defect, and the only substantiated diagnosis is chronic lumbosacral strain without any evidence of significant muscle spasm. Under these circumstances, the Court concludes that there is substantial evidence in the record for the administrative law judge's determination that physically plaintiff retains the residual functional capacity for light work as that term is defined in 20 C.F.R. § 404.1510(c).

Plaintiff contends that the Medical-Vocational Guidelines set out in Subpart P, Appendix 2 are not applicable to his case because he also suffers from the non-exertional nervous condition. The Guidelines provide that "they may not be fully applicable where the nature of an individual's impairment does not result in" physical limitations in the claimant's ability to meet strength requirements of jobs. Section 200.00(e), Subpart P, Appendix 2—Medical-Vocational Guidelines. When there are combined exertional and non-exertional impairments which result in both strength limitations and non-exertional limitations, the Medical-Vocational Guidelines are applied first to determine whether plaintiff may be disabled by strength limitations alone. If he is not disabled by strength limitations alone, then the Guidelines "provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs which would be contraindicated by non-exertional limitations." Section 200.00(e)(2), Subpart P, Appendix 2—Medical-Vocational Guidelines.

[6] In the present case, plaintiff's physical limitations do not preclude light work. The question, then, is whether his nervousness results in non-exertional work related limitations. There is no evidence of any of the types of non-exertional limitations on employment as set in § 12.04, Subpart P, Appendix 1—Listing of Impairments. Further, there is no evidence that plaintiff would be unable to follow work instructions, would be unable to get along with his supervisors and co-employees, or would be unable to concentrate on and pay attention to work processes. Under these circumstances, the Court concludes that the administrative law judge did not err in applying the Medical-Vocational Guidelines to determine that plaintiff, considering his age, education and prior work experience, is able to engage in substantial gainful activity generally available in the national economy.

[7] Plaintiff contends that because the Medical-Vocational Guidelines do not refer to specific jobs, the Secretary has not discharged his duty of demonstrating that plaintiff can perform substantial gainful work. He relies upon a statement in *Hephner v. Mathews*, 574 F.2d 359, 362-363 (6th Cir. 1978) that "a finding of capacity to work" cannot be "expressed . . . in terms of a vague catch-all phrase such as 'light' work." Instead, it must be "in terms of specific types of jobs." First, the administrative law judge's determination that plaintiff retains the residual functional capacity to perform light work is not standardless. The term "light work" is defined by 20 C.F.R. § 404.1510(c). Second, the Medical-Vocational Guidelines have been adopted by the Secretary since the decision in *Hephner* to reduce the need for vocational testimony and to attempt to eliminate variance in individual cases where the claimants have essentially the same physical and non-exertional limitations. The Medical-Vocational Guidelines are based on administrative notice the Secretary has taken of jobs generally available in the national economy. The Secretary evaluated information contained in the *Dictionary of Occupational Titles*, published by the Department of Labor, *County Business Patterns*, published by the Bureau of Census, *Census Reports, Occupational Analyses*, prepared by the Social Security Administration, the *Occupational Outlook Handbook*, published by the Bureau of Labor Statistics, and other generally available information relating to the age, educational, work experience, and exertional demands of various jobs. See, 20 C.F.R. § 404.1566(d)(August 20, 1980). Since "these tables and rules are based on a wealth of information available about jobs existing in the national economy" vocational expert testimony is unnecessary in most cases. *Jones v. Harris*, ¶ 17, 074 CCH Unemployment Ins.Rptr. (E.D. Tenn. March 18, 1980). The Court has carefully re-

viewed the record and concludes that there are no unusual facts in the present case which would have required the administrative law judge to seek the assistance of a vocational expert.

WHEREUPON, the Court HOLDS that plaintiff's motion for summary judgment and remand is without merit; and, therefore, it is DENIED. The Court FURTHER HOLDS that defendant's motion for summary judgment is meritorious; and, therefore, it is GRANTED.

The decision of the Secretary of Health, Education and Welfare is AFFIRMED. This action is hereby DISMISSED.

LYDICK, District Judge:

PROCEEDINGS

On March 21, 1980, plaintiff filed a complaint to review the decision of the Secretary of Health, Education and Welfare denying his claim for disability insurance benefits.

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APPLICABLE LAW

It is clear that the burden of proof is on the plaintiff to establish entitlement to benefits under the Act. *Harmon* v. *Finch*, 460 F.2d 1229, 1231 (9th Cir. 1972), *cert. denied*, 409 U.S. 1063 (1972), *reh. denied*, 410 U.S. 918 (1973); *Waters* v. *Gardner*, 452 F.2d 855, 857 (9th Cir. 1971); *Rhinehart* v. *Finch*, 438 F.2d 920, 921 (9th Cir. 1971); *Mark* v. *Celebrezze*, 348 F.2d 289, 293 (9th Cir. 1965); *McMullen* v. *Celebrezze*, 335 F.2d 811, 814 (9th Cir. 1964), *cert. denied*, 382 U.S. 854 (1965), reh. denied, 382 U.S. 922 (1965).

The statutory definition of "disability" is "much narrower than the word itself, standing alone, might indicate," since it requires that the claimant "be unable to 'engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which could be expected to result in death or which has lasted or could be expected to last for a continuous period of not less than 12 months.'" *Harmon* v. *Finch, supra*, at 1230, quoting 42 U.S.C. § 423(d)(1)(A). The statutory definition has been incorporated in the Social Security regulations. 20 C.F.R. § 404.1501(a)(i).

The definition was further restricted by the Congress, effective January 2, 1968, by enacting the following provisions set out in 42 U.S.C. § 423(d)(2)(A): "(A) an individual . . . shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work." *Harmon* v. *Finch, supra*, at 1230-1231; *Chavies* v. *Finch*, 443 F.2d 356, 357 (9th Cir. 1971). These restrictive definitions were enacted in part to correct court decisions that the Congress considered to be too liberal. *Harmon* v. *Finch, supra*, at 1231.

The Social Security Act requires that the plaintiff's disability be demonstrated by medically acceptable clinical and laboratory diagnostic techniques. 42 U.S.C. § 423(d)(3). The Act further provides that a claimant shall not be considered to be under a disability unless the claimant furnishes such medical and other evidence of the existence thereof as the Secretary may require. 42 U.S.C. § 423(d)(5).

The implementing regulations of the Social Security Administration, 20 C.F.R. § 404.1524(c), provides in pertinent part as follows:

> [S]uch evidence shall also describe the individual's capacity to perform significant functions such as the capacity to sit, stand, move about, travel, handle objects, hear or speak. . . . The clinical and laboratory findings shall be sufficiently comprehensive and detailed to permit the making of independent determinations by the Administration . . . as to the nature and limiting effects of the individual's physical or mental impairments for the period in question, his ability to engage in physical or mental activities, and the probable duration of such impairment.

SCOPE OF REVIEW

Under § 205(g) of the Social Security Act, 42 U.S.C. § 405(g), the jurisdiction of the court is limited to the question of whether or not the findings of the Secretary of Health, Education and Welfare are supported by substantial evidence. If they are, the Secretary's findings are conclusive. *Harris* v. *Richardson*, 468 F.2d 1260 (9th Cir. 1972), *cert. denied*, 410 U.S. 986 (1973); *Harmon* v. *Finch*, 460 F.2d 1229, 1230 (9th Cir. 1972), *cert. denied*, 409 U.S. 1063 (1972), *reh. denied*, 410 U.S. 918 (1973); and *Chavies* v. *Finch*, 443 F.2d 356, 357 (9th Cir. 1971).

Therefore, the ultimate question to be determined by the Court is whether the final decision of the Secretary is supported by substantial evidence reasonably based on the record as a whole. *Walker* v. *Mathews*, 546 F.2d 814, 818 (9th Cir. 1976); *Beane* v. *Richardson*, 457 F.2d 758, 759 (9th Cir. 1972), *cert. denied*, 409 U.S. 859 (1972); *Rhinehart* v. *Finch*, 438 F.2d 920, 921-922 (9th Cir. 1971).

PLAINTIFF'S CLAIMS

On January 25, 1979, plaintiff filed an application for disability insurance benefits alleging that he became unable to work on August 1, 1978, at age 41, because of lower back pain.

In his motion for summary judgment, plaintiff alleges that by utilizing the new regulations, 20 C.F.R. §§ 404.1503-404.1513; Subpart P, Appendix 2, the Secretary has failed to comply with the ruling in *Hall* v. *Secretary of Health, Education and Welfare*, 602 F.2d 1372 (9th Cir. 1979), requiring that the Secretary identify specific jobs which a claimant is capable of performing, and thus has failed to satisfy the Secretary's burden of showing alternate employability through vocational capacity. [Memo in Spt of Mot S/J 9.] Other cases are also cited in support of this argument. [*Id.* at 9-18.]

SECRETARY'S DECISION

On October 2, 1979, the administrative law judge held a hearing in which the plaintiff appeared in person and testified and was represented by the same attorney who represents him in the present action.

After careful consideration of the entire record, the administrative law judge made the following pertinent findings:

> . . .
>
> 3. The medical evidence discloses findings of chronic sprain/strain of the lumbar spine, with x-ray evidence of small myelographic defects at L4-5, consistent with the possibility of a herniated disc.
>
> 4. The medical evidence, including expert medical opinion, warrants a finding that the claimant can sustain sedentary work activity without undue symptom exacerbation.
>
> 5. The claimant's allegations of severe pain and disabling limitation appeared exaggerated, out of proportion to the medical findings as well as medical opinion and, consequently, cannot be reasonably accepted as accurate or credible.
>
> 6. The medical evidence together with the claimant's testimony, appearance, and demeanor at the hearing, warrants a finding that the claimant can sustain sedentary work activity without undue symptom exacerbation.
>
> 7. The claimant is unable to return to his past relevant work as either an automotive detail man or janitor in that such occupations exceed the claimant's present residual functional capacity.
>
> 8. The claimaint is a younger individual at age 42, has a limited 10th grade education, and past relevant work experience of an unskilled nature.
>
> 9. The claimant's residual functional capacity for sedentary work activity, together with the above vocational factors, match the criteria of Rule 201/24, Table 1, Appendix 2, Subpart P of Regulations No. 4, wherein the Secretary directs a factual conclusion that the claimant is not under a "disability" within the meaning of the Social Security Act, as amended.

DISCUSSION

* * * * *

It was the finding of the administrative law judge that the plaintiff was able to perform sedentary work. It will be noted from the proposed Findings of Fact that the doctors who gave an opinion on plaintiff's work capability indicated that he was either capable of light or sedentary work. Accordingly, the administrative law judge's decision is not in conflict with, but was rather supported by, the medical evidence of record.

The plaintiff does not dispute the fact that the administrative law judge made his determination by following the procedure set out in the new regulations. Plaintiff contends that the fundamental issue in this case is whether, once the claimant can no longer return to his former employment, the Secretary can satisfy the burden of showing alternate employability only through reference to the newly enacted Social Security regulations, 20 C.F.R. §§ 404.1502-404.1513 (1980), which became effective February 26, 1979. [43 F.R. 55379, November 28, 1978.] Plaintiff argues that reliance on the regulations alone is insufficient and cites *Hall v. Secretary of Health, Education and Welfare*, 602 F.2d 1372 (9th Cir. 1979), to support the argument that the Secretary must identify specific jobs which the claimant is capable of performing, preferably through the testimony of a vocational expert, and that reliance solely on the regulations is merely a theoretical determination of whether a particular claimant is capable of performing substantial gainful activity. [Opp. 1-2; Pltf's Supp. Memo. 1-5.]

Hall did not involve a ruling on the new regulations. The issue then is whether *Hall* should be applied to a case involving the application of the new regulations or whether the new regulations provide sufficient vocational guidance to permit the administrative law judge to dispense with the use of a vocational expert in plaintiff's case.

The use of the new regulations was approved by the court in *Hicks v. Califano*, 600 F.2d 1048 (4th Cir. 1979), in a case where the appeal before the court was pending at the time the regulations became effective on February 26, 1979. Said the court:

> . . . The regulations define each factor to be considered in determining whether disability exists. 20 C.F.R. §§ 404.1505 to 1511. More importantly, they direct a finding of disability or no disability where the findings of fact in a particular case coincide with the criteria established in the rules and tables of Subpart P, Appendix 2. 20 C.F.R. § 404.1513.

Id. at 1050. The court ordered that the case

> be remanded to the Secretary for determination of the nature and transferability of claimant's skills, and, upon making such a determination, the Secretary should be ordered to find claimant disabled or not disabled as required by the new regulations.

Id.

Since the court found an error in the administrative law judge's use of the vocational expert's testimony at the initial hearing, the administrative law judge was ordered to present to the vocational expert not just the fact of the claimant's back impairment due to arthritis but to present to the vocational expert the medical evidence with respect to all of the claimant's disabilities. *Id.* at 1051. The court, however, did not indicate that a vocational expert's opinion was necessary in addition to the administrative law judge's determination under the new regulations.

Plaintiff cites *O'Banner* v. *Secretary of Health, Education and Welfare*, 587 F.2d 321, 323 (6th Cir. 1978), and *Wilson* v. *Califano*, 617 F.2d 1050 (4th Cir. 1980), to show that other circuit follow a rule similar to that of the Ninth Circuit in *Hall*. [Supp. Memo. 2.] Although this is true, these two cases, like *Hall*, did not involve a ruling on the new regulations.

In *Phillips* v. *Harris*, 488 F.Supp. 1161 (W.D. Va. 1980), also cited by plaintiff, the court held that the promulgation of the new regulations clearly constituted a valid exercise of the Secretary's statutory responsibility under 42 U.S.C. § 405(a), and that the new regulations were "not patently defective." *Id.* at 1165. However, the court found that the way in which the new regulations were applied in that case precluded a finding of substantial evidence to support the Secretary's decision. *Id.*

Thus, in case of both plaintiffs Mullins and Phillips, the administrative law judge had found that they suffered from some sort of emotional impairment, which impairments under § 404.1504(d) of the new regulations result in "non-exertional limitations." *Id.* at 1166.

> . . . When "non-exertional limitations" are present, the regulations provide that the rules of Appendix II cannot be applied so as to *require* a finding of not disabled. See Rule 200.00(e) of Appendix II to Subpart P of the Administrative Regulations No. 4. Thus, in the instant cases, the Law Judge erred in finding that the new regulations required a finding of not disabled.

Id. at 1166. The court also found that the administrative law judge had not given sufficient consideration to the emotional impairment of the claimants. *Id.*

Phillips further held that "the Secretary has failed to discharge the burden of going forward with evidence of capacity for a specific alternate job in the national economy and proof of transferable skills." *Id.* at 1167. The court acknowledged that 20 C.F.R. § 404.1509(c) provides that in determining whether jobs, as classified by their exertional and skill requirements, existed in significant numbers, administrative notice could be taken of reliable job information available from various governmental and other publications such as the "Dictionary of Occupational Titles." Nevertheless, the court held that this determination was not within the administrative law judge's discretion based solely on his own expertise. *Id.* at 1167.

In that case, claimant Phillips was over 50 years of age and functionally illiterate. Claimant Mullins was 53 years old and her work experience was limited to that of a cook. The court drew attention to Rule 201.00(g) of Appendix 2 to Subpart P, which acknowledges that "individuals approaching advanced age (age 50-54) may be significantly limited in vocational adaptability if they are restricted to sedentary work." *Id.* at 1168. It was the opinion of the court that

> . . . In close cases such as those at hand, it cannot be said that the final decision of the Secretary is supported by "substantial evidence" when that decision is based, in essence, on nothing more than speculation by the administrative law judge.

However, the court also concluded that while it found it necessary to remand the cases for further development,

> The opinion of the court should not be read to indicate that testimony of vocational experts is always necessary in cases when the sequential evaluation of the new regulations reaches step five . . . In cases of *prima facie* disability decided subsequent to entry of this opinion . . . the final decision of the Secretary will be reversed when reasonable questions regarding the transferability of work skills are not resolved in an appropriate manner. The court is of the opinion that the existing case law in this circuit is sufficient to apprise the Secretary as to what constitutes an appropriate response in a given factual situation.

Id. at 1169.

Certain facts distinguishing *Phillips* from the present case should be pointed out. Plaintiff, in the present case, does not suffer from any emotional or mental impairment. He alleged that he became unable to work at age 41, thus being classified as a younger individual, being well under age 50. 20 C.F.R. § 404.15(6)(b)[sic]. Therefore, his age is not considered to affect significantly his ability to adapt to a new work situation. *Id*. Moreover, he is not illiterate. As will be elaborated on below, the administrative law judge's decision was not based on pure speculation.

Defendant has attached to defendant's supplemental memorandum a copy of the opinion in *Stallings* v. *Harris*, No. 79-1051 (W.D. Tenn. 7/10/80). This case views the administrative law judge's discretion under the new regulations in a different light. The following excerpt from the opinion is worthy of consideration:

> Plaintiff contends that the agency's administrative notice of materials contained in studies and treatises constitutes an improper substitution for its burden of proof in cases in which it is determined that a claimant is unable to perform his or her previous work. The agency concedes that in such cases it has an obligation to demonstrate the availability of jobs that the claimant has the functional and vocational capacity to perform. *See, e.g.*, *Gray* v. *Finch*, 427 F.2d 598 (6th Cir. 1970).
>
> As defendant correctly notes, however, the regulations are consistent with this judicial burden because they require complete consideration of a claimant's individual circumstances. In place of vocational testimony that jobs exist or do not exist that a claimant can perform, the regulations have incorporated extensive information from the same sources that a vocational expert would utilize. In addition, this information is specifically related to previous individualized findings with respect to a claimant's functional and vocational capacity. Thus the regulations meet the agency's burden in a manner that may afford more consistent and uniform results.

Id. at 6.

The administrative law judge found the plaintff to be capable of sedentary work, which is defined as work entailing lifting 10 pounds maximum and involving sitting, although a certain amount of walking and standing may be necessary to carry out job duties. 20 C.F.R. § 404.1510(b). Sedentary work involves the lowest level of exertional requirements.

The preamble to the new regulations includes the following comment:

> In order to consider the individual's residual functional capacity in terms of the level of work his or her exertional capabilities would represent, the definitions of sedentary, light, medium, heavy and very heavy work are use [sic] as those terms are defined in the third edition of the *Dictionary of Occupational Titles* published by the Department of Labor. This provides a "bridge" between assessment of residual functional capacity and the identification of ranges of work and types of jobs that remain within the individual's functional capabilities. The rules attach *vocational* significance to the functional capability for various ranges of work in terms of the relative numbers of jobs represented by the various capabilities. [Emphasis added.]

43 F.R. 55352 (November 28, 1978). Thus,

> . . . Approximately 1,600 separate unskilled light and sedentary occupations can be identified in the *Supplement to the Dictionary of Occupational Titles* (third edition), each occupation representing numerous jobs found throughout the national economy.
>
> Most sedentary occupations are skilled or semi-skilled, and fall within the professional, administrative, technical, clerical, machine trade, and benchwork classifications. There are also approximately 200 separate unskilled sedentary occupations which can be identified in the *Supplement to the Dictionary of Occupational Titles* (third edition), each occupation representing numerous jobs found throughout the national economy. . . .

Id.

The present law of this circuit has been stated in *Hall* v. *Secretary of Health, Education and Welfare*, 602 F.2d 1372, 1377 (9th Cir. 1979), as follows:

> . . . A general statement that a claimant may engage in "sedentary" work, without testimony by a vocational expert who can identify specific jobs, absent other reliable evidence of the claimant's ability to engage in other occupations, does not satisfy the substantial evidence test.
>
> It is incumbent on the Secretary at a minimum, to come forward with specific findings showing that the claimant has the

> physical and mental capacity to perform specified jobs, taking into consideration the requirements of the job as well as the claimant's age, education, and background. [Citations omitted.]
>
> Ordinarily, the better method to demonstrate this is through testimony of a vocational expert. *See O'Banner*, 587 F.2d at 323; *Garrett*, 471 F.2d at 603-04. Although there is no per se rule that a vocational expert's evaluation is necessary, the Secretary must be diligent in developing the facts where, as here, the claimant was not assisted by counsel. *Cox* v. *Califano*, 587 F.2d at 991.

Plaintiff's case is distinguishable from *Hall* in that he was represented at the administrative hearing by the same attorney who represents him in the present case and the facts appear to have been adequately developed. His impairment was low back pain, due possibly to a herniated disc. His impairments therefore affected only the exertional requirements of his work activity. 20 C.F.R. § 404.1510. He had a tenth grade education and prior experience as an automobile detail man and janitor.

There does not appear to be any substantial question concerning the transferability of plaintiff's skills. The administrative law judge found his past work experience was of an unskilled nature. Unskilled work is defined as "work which requires little or no judgment in the performance of simple duties that can be learned on the job in a short period of time." 20 C.F.R. § 404.1511(b). As indicated above, there are over 200 separate unskilled sedentary occupations identified in the Supplement to the Dictionary of Occupational Titles. There has been no showing whatsoever that plaintiff does not have the capacity to adapt to a sedentary type job, the duties of which can be learned on the job in a short period of time. These were the vocational factors which were expressly considered by the administrative law judge in his opinion.

Therefore, on the record in plaintiff's case, there does not appear to be any substantial reason to doubt that the plaintiff was capable of performing numerous sedentary jobs listed in the Supplement to the Dictionary of Occupational Titles, a publication which is utilized by vocational experts in their testimony. Although a vocational expert, if called to testify, would identify specific jobs from the Supplement to the Dictionary of Occupational Titles, this does not appear to be necessary in plaintiff's case. Plaintiff's case is not a close one, as was true in *Phillips* v. *Harris, supra*, cited by plaintiff. The administrative law judge was not relying solely on his own expertise, his findings were not pure speculation and there was no reasonable question as to transferability of skills. His decision was not theoretical but had a basis in fact. Moreover, the court in *Phillips* v. *Harris* acknowledged that where the potential for alternate work was "within the common knowledge and experience of ordinary men," substantiation by a vocational expert was not necessary. 488 F.Supp. at 1167, citing *McLamore* v. *Weinberger*, 538 F.2d 571, 575 (4th Cir. 1976). This was likewise the ruling in *Holguin* v. *Harris*, 480 F.Supp. 1171, 1181 (N.D. Cal. 1979), where the court stated:

> . . . Where the conclusion of the Secretary is within the common knowledge and experience of ordinary men, it requires no substantiation by a vocational expert.

Accordingly, it appears that under the present law of this circuit, the substantial evidence rule does not require that the decision of the administrative law judge be further supported by the testimony of a vocational expert.

★ ★ ★ ★ ★

IT IS ORDERED that judgment be entered in favor of defendant and against the plaintiff, dismissing the complaint and action on the merits and affirming the decision of the Secretary of Health, Education and Welfare.

SECTIONS 216(i) and 223(d) (42 U.S.C. 416(i) and 423(d)) DISABILITY INSURANCE BENEFITS—INABILITY TO PERFORM PREVIOUS WORK—EXISTENCE OF UNSKILLED SEDENTARY JOBS

SSR 82-35c

20 CFR 404.1503-404.1513*

Jones v. Harris, 1A Unemployment Insurance Reporter (1980 Transfer Binder) ¶17,074 (E.D. TENN., Northern Div. 1980)

The plaintiff, who is 39 years old and has an eleventh grade education, applied for Disability Insurance Benefits, alleging that he was totally disabled because of a back injury and the pain resulting from it. Although the plaintiff is unable to perform the tasks required by his former occupation, the evidence of record fails to show that he suffers from any exertional or nonexertional impairments or symptoms, including pain, which would prevent him from performing unskilled sedentary work. When the Social Security Administration (SSA) determined, under Rule 201.24 in Table 1 of Appendix 2, Subpart P, Regulations No. 4, that the plaintiff was not disabled and denied his application, the plaintiff appealed. He contended that SSA had failed to prove that there was work in the national economy which he could perform. *Held*, live testimony regarding the existence of work in the national economy which the plaintiff could perform is unnecessary because the rules and tables in Appendix 2 (as pointed out in 20 CFR 404.1513) are based on a wealth of available information concerning the existence of such jobs. *Further held*, SSA's finding that the plaintiff meets each of the criteria in Rule 201.24 is supported by substantial evidence and thus SSA's determination that the plaintiff is not disabled must be affirmed.

TAYLOR, District Judge:

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*The regulations used to make disability determinations under titles II and XVI of the Social Security Act were recodified effective August 20, 1980. See 45 FR 55566-55634 (1980) (recodified in 20 CFR 404.1501-404.1598 and 20 CFR 416.901-416.996). The regulations cited in this ruling have been renumbered and rewritten as part of the recodification, but not substantively changed. See §404.1560-§404.1569 and Rule 201.24, Appendix 2, Subpart P of Regulations No. 4.

The plaintiff is a 39-year-old man with an eleventh grade education. He has had some mechanical training and experience, but his occupation at the time of his injury was a grocery store stock clerk. Around the first of April, 1977, plaintiff suffered a herniated disc while working. Although this injury was surgically treated, plaintiff claims the injury to his back, with attendant pain, totally disables him.

Plaintiff's application for disability benefits was filed on October 3, 1977. His claim was denied initially and upon reconsideration. Plaintiff reapplied for benefits, and was denied again. An administrative hearing on plaintiff's claim was held on July 17, 1979. The Administrative Law Judge (ALJ) found plaintiff not to be disabled and denied benefits. This decision was approved by the Social Security Appeals Council, thereby becoming the final decision of the Secretary of Health, Education and Welfare. The only question before this Court is whether the Secretary's finding of no disability is supported by substantial evidence.

The plaintiff's treating physician, Dr. James Riccardi, an orthopedic surgeon, reported that plaintiff could not perform repetitive heavy lifting as was required in his former occupation. Dr. Riccardi felt plaintiff could perform a full range of sedentary work and characterized plaintiff's pain as mild and intermittent.

Doctor Samuel Marcy, an orthopedic surgeon, said repeated bending and stooping would cause "rapid recurrence of significant back pain" and that "light work" as defined by the Social Security Administration would be too strenuous. Dr. Marcy concluded that "bench-type vocational rehabilitation work would be in order."

Doctor Edward Tauxe, an orthopedic surgeon, said plaintiff is "unable to do significant bending, stooping, and lifting."

The ALJ found that plaintiff is prevented from doing his former occupation but is not prevented from performing sedentary labor. The ALJ specifically discounted pain, insofar as it would prevent sedentary work, because of a lack of objective medical findings consistent with such pain.

In the opinion of the Court, these findings are all supported by substantial evidence, and in fact are not contradicted in the record. In 20 C.F.R. § 416.910 sedentary work is defined as occasionally lifting no more than ten pounds, and sitting with occasional walking and standing. The recommendations of Dr. Tauxe and Dr. Marcy against stooping, bending, or significant lifting are not inconsistent with this definition of sedentary labor.

Plaintiff complains that the Secretary has not carried his burden of proving that there is work in the national economy which plaintiff can perform, as required by *Hephner v. Matthews*, 574 F.2d 359, 361 (6th Cir. 1978). It is true that the record contains no concrete evidence in this regard. In the past such evidence was usually provided by the testimony of a vocational expert. The Secretary now relies on the regulations found at 20 C.F.R. § 404.1513 and Appendix 2 to Subpart P of the Social Security Regulations. Section 200.00(b) of Appendix 2 provides as follows:

> The existence of jobs in the national economy is reflected in the "Decisions" shown in the rules; i.e. in promulgating the rules, administrative notice has been taken of the numbers of unskilled jobs that exist throughout the national economy at the various functional levels, . . . Thus, when all factors coincide with the criteria of a rule, the existence of such jobs is established. . . .

The ALJ found that plaintiff is a younger individual, between 18 and 44, with a limited education, had only unskilled work experience and could perform sedentary labor. The ALJ further found that plaintiff suffered no non-exertional impairments, such as pain, which would prevent him from performing a full range of sedentary labor. Each of these findings is supported by substantial evidence. Thus, plaintiff fits all the criteria found in Table No. 1 of Appendix 2, Rule 201.24. This rule directs a finding of not disabled in such a case, on the grounds that significant numbers of jobs do exist which a person of plaintiff's age, experience, background and physical capacity could perform, Section 201.00(h), 20 C.F.R. Subpart P, App. 2. As Regulation number 404.1513 points out, these tables and rules are based on a wealth of information available about jobs existing in the national economy, making live testimony on such information unnecessary. The Secretary carries his burden of proof by supporting with substantial evidence findings that claimant meets each criterion in a particular rule in Appendix 2.

Accordingly, it is ORDERED that the Secretary's decision in this case be, and the same hereby is, affirmed.

Order Accordingly.

SECTIONS 216(i) and 223(d) (42 U.S.C. 416(i) and 423(d)) DISABILITY INSURANCE BENEFITS—INABILITY TO PERFORM PREVIOUS WORK—EXISTENCE OF OTHER PERFORMABLE WORK

20 CFR 404.1560-404.1569 **SSR 82-36c**

Simonsen v. Secy., HHS, USDC, S.D. CALIF., Civ. No. 79-927-T (1/14/81)

The plaintiff, who had back surgery and complained of numbness in his leg, appealed the denial of his application for Disability Insurance Benefits. The Social Security Administration (SSA) had determined that the plaintiff was incapable of performing his former job as a painter, but that he still had the ability to do light work. In making this determination, SSA did not specify exactly what kind of light work the plaintiff could perform. The plaintiff alleged that he had been hospitalized and had undergone further surgery since the administrative hearing, but he failed to submit corroborating evidence in support of this contention. Since the plaintiff's impairment prevented him from performing his former job, the court found in its review that the regulations on vocational considerations permitted SSA to consider the plaintiff's age, education, and other factors in determining whether he could perform other work. *Held*, the plaintiff's unsubstantiated allegation regarding the existence of relevant evidence pertaining to his medical treatment since the administrative hearing was insufficient to support a remand order. *Further held*, because the new vocational regulations take administrative notice of unskilled jobs in the national economy, SSA was not required to point out a particular job that the plaintiff could perform. *Further held*, the medical evidence of record supported SSA's determination that the plaintiff was not disabled.

TURRENTINE, District Judge:

Claimant seeks judicial review of the denial of his claim for disability insurance benefits by the Secretary of Health and Human Services. See 42 U.S.C. § 405(g). The Secretary has moved for summary judgment. The Magistrate has made a recommendation that the case be remanded for the taking of further evidence, to which the Secretary has objected. Local Rule 506. The limited role of a district court under 42 U.S.C. § 405(g) is to determine whether the Secretary's findings are supported by substantial evidence. *Chavies v. Finch*, 443 F.2d 356, 357 (9th Cir. 1971).

The Administrative Law Judge (ALJ) found that claimant was no longer capable of performing his former work as a painter, but that he still had the ability to do work of a light nature. Claimant has had back surgery and complains of numbness in his leg.

Apparently remand has been suggested to take evidence on further surgery and a hospital stay which occurred after the administrative hearing. But claimant has failed to tender any new evidence to the Court. The Secretary's Appeals Council, in affirming the ALJ's decision, invited claimant to submit updated evidence in a letter dated June 29, 1979, but at no time has he submitted any additional evidence which would call for remand. *See Perez v. Mathews*, 411 F.Supp. 1276, 1279-80 (E.D. Cal. 1976). His unsubstantiated assertion that there is additional relevant evidence is insufficient to support a remand order. *Hall v.*

Secretary of HEW, 602 F.2d 1372, 1377 (9th Cir. 1979); *Hutchinson v. Weinberger*, 399 F.Supp. 426, 428 (E.D. Mich. 1975). In addition, the failure to present the new evidence prevents the Court from determining whether there is a reasonable chance the Secretary would reach a different conclusion based on this evidence. *See Lindberg v. Califano*, 469 F.Supp. 920, 921 (N.D. Cal. 1979) (Williams, J.).

As to whether substantial evidence supports the Secretary's decision, the record contains medical evidence which indicates claimant is not completely disabled. While it is true that there is evidence which could support a contrary conclusion, it is up to the Secretary to resolve conflicts in the evidence, and the Court should not substitute its own judgment. *Jacobs v. Finch*, 421 F.2d 843 (9th Cir. 1970).

There is a question whether the Secretary erred in not specifying exactly what kind of light work plaintiff is capable of performing. *See Hall*, 602 F.2d at 1377. The reason no job was specified is that new regulations basically eliminate the need for a vocational expert to testify. Instead, the regulations call for examination of age, education, and other factors. If the claimant's characteristics meet those set out in the regulations, then he is conclusively either disabled or not disabled, depending on which regulation is being used. Thus, the Secretary committed no error in not pointing to a particular job which plaintiff is capable of performing. *See Boyce v. Harris*, 492 F.Supp. 751, 752 (D. S.C. 1980); *Crowe v. Harris*, 489 F.Supp. 683, 689 (E.D. Tenn. 1980).

If claimant's condition has worsened since the Secretary's decision, he is free to file a new disability claim for his present condition. Based on the present record summary judgment should be granted for the Secretary.

SO ORDERED.

SECTIONS 1614(f) (3) and 1621 (42 U.S.C. 1382c(f) (3) and 1382j) SUPPLEMENTAL SECURITY INCOME—ELIGIBILITY—DEEMING OF INCOME AND RESOURCES FROM AN ALIEN'S SPONSOR

SSR 82-37

20 CFR 416.1160(a) (2)

The claimant is an alien whose entrance into the United States (U.S.) on August 2, 1980 was sponsored by the husband of his wife's cousin. On November 4, 1980, the claimant applied for Supplemental Security Income (SSI) benefits. When the Social Security Administration (SSA) determined that the claimant was ineligible for SSI benefits because his income and resources exceeded the statutory limits, he appealed. Under a provision in section 1621 of the Social Security Act (the Act), the claimant's income and resources were deemed to include the income and resources of his sponsor. None of the exceptions to that provision was applicable to the claimant. *Held*, with the inclusion of the sponsor's income and resources, the claimant was ineligible for SSI benefits because his income and resources exceeded the statutory limits.

The issue is whether the claimant should have the income and resources of his sponsor deemed to him for purposes of determining his eligibility for SSI benefits.

The claimant's immigration to the U.S. from Taiwan on August 2, 1980 was sponsored by the husband of his wife's cousin. The claimant is almost totally paralyzed resulting from viral myelitis contracted while an employee of the U.S. Navy Medical Research Unit during the 1960's.

Following his arrival in the U.S., the claimant and his wife applied for Aid to Families with Dependent Children and for food stamps. He also applied for SSI benefits on November 4, 1980. The claimant and his family do not live with the sponsor and his spouse, but they do live in the household of another couple. The claimant alleged that neither he nor his family had made any contributions towards household expenses.

On December 6, 1980, the claimant was notified that part of the income and property owned by the claimant's sponsor had been deemed to the claimant for a 3-year period. The sponsor, who is a doctor, filed a Statement of Income and Resources on December 10, 1980, in which he disclosed annual income of $63,000.00 and resources in excess of $15,000.00. The basis for the claimant's appeal is his belief that it was unfair to deem the income and resources of his sponsor to him since he was allowed to enter the U.S. because he had received his disabling impairment while an employee of the U.S. Navy.

Section 1621(a) of the Act provides that—"For purposes of determining eligibility for and the amount of benefits under this title for an individual who is an alien, the income and resources of any person who (as a sponsor of such individual's entry into the United States) executed an affidavit of support or similar agreement with respect to such individual, and the income and resources of the sponsor's spouse, shall be deemed to be the income and resources of such individual (in accordance with subsections (b) and (c)) for a period of three years after the individual's entry into the United States. Any such income deemed to be income of such individual shall be treated as unearned income of such individual."

Section 1621(f) of the Act provides that—"(1) The provisions of this section shall not apply with respect to any individual who is an "aged, blind, or disabled individual" for purposes of this title by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)), from and after the onset of the impairment, if such blindness or disability commenced after the date of such individual's admission into the United States for permanent residence. (2) The provisions of this section shall not apply with respect to any alien who is—

> (A) admitted to the United States as a result of the application, prior to April 1, 1980, of the provisions of section 203(a)(7) of the Immigration and Nationality Act;
>
> (B) admitted to the United States as a result of the application, after March 31, 1980, of the provisions of section 207(c)(1) of such Act;

(C) paroled into the United States as a refugee under section 212(d)(5) of such Act; or
(D) granted political asylum by the Attorney General."

At his hearing, the claimant requested special humanitarian consideration in his case. While SSA was sympathetic to the plight of the claimant, it was bound by the deeming provision in section 1621 of the Act, and the claimant did not meet any of the exceptions to that provision. Hence, SSA had no alternative but to find that the income and resources of the claimant's sponsor were deemable to the claimant through July 1983. Accordingly, SSA determined that the claimant was ineligible for SSI benefits because his income and resources exceeded the statutory limits.

SECTIONS 459, 1612(a)(2)(B), and 1612(b) (42 U.S.C. 659, 1382a(a)(2)(B), and 1382a(b)) SUPPLEMENTAL SECURITY INCOME—UNEARNED INCOME—SOCIAL SECURITY BENEFITS SUBJECT TO GARNISHMENT FOR CHILD SUPPORT OR ALIMONY

20 CFR 416.1121(a) and 416.1124 **SSR 82-38**

The claimant, who was born August 24, 1914, applied for Supplemental Security Income (SSI) benefits in August 1980. The Social Security Administration (SSA) determined that the claimant was ineligible for SSI benefits because he had excess countable income. The claimant appealed because SSA included as a part of his countable income the full amount of his Social Security benefits although one-half of his monthly Social Security benefit was being withheld under the garnishment provisions of section 459 of the Social Security Act (the Act). The withheld amount was being paid to his daughter until the $12,859.50 he owed in child support arrearages was paid. The claimant contended that the amount of the reduction of his Social Security benefits due to garnishment should be excluded in determining his income for SSI eligibility purposes. *Held*, neither the law nor the regulations provide for the reduction of income because of garnishment. *Further held*, since the amount of the claimant's Social Security benefits before garnishment constitutes unearned income, he is ineligible for SSI benefits because of his excess income.

The issue is whether that portion of the claimant's Old-Age Insurance Benefits which is allocated for satisfaction of a garnishment order is excludable from unearned income in determining his eligibility for SSI benefits.

The claimant, who was born August 24, 1914, applied for SSI benefits on August 15, 1980. When SSA determined that the claimant was ineligible for SSI benefits because he had excess countable income, the claimant appealed contending that he was no longer able to meet his living expenses without additional help.

The claimant testified that when he and his wife were divorced in 1970, she was granted custody of his daughter. Under the provisions of the property settlement agreement, the claimant's ex-wife was given their home, their $10,000 bank account, and large sums of personal property, including an automobile. In addition, the claimant was ordered to pay $80 per month for the support of his daughter. He began making those payments in 1970 but ceased making them in 1971 when his ex-wife disappeared and he learned that she had changed his daughter's surname to that of her new husband. The claimant later became entitled to both Old-Age Insurance Benefits and a VA pension, and his daughter became entitled to Child's Insurance Benefits on his earnings record.

The claimant had neither spoken to his ex-wife since their divorce nor received any communication regarding the nonpayment of child support until April 1980. At that time, a money judgment, dated April 22, 1980, in the amount of $12,859.50 was entered against the claimant for retroactive child support payments, interest, and costs. On July 23, 1980, the claimant was informed by SSA that it had been served with a garnishment order on June 2, 1980 in execution of the money judgement against him and that it would begin withholding 50% of his Social Security benefits to satisfy the order.

The claimant does not challenge the existence or amount of the debt, and he does not question his legal obligation to repay it. He does dispute, however, the inclusion of his Social Security benefits before garnishment, rather than the amount after garnishment, as income for purposes of determining his eligibility for SSI benefits. If the amount of the reduction of the claimant's Social Security benefits due to garnishment was excluded in determining his countable income, he would be eligible for SSI benefits. The claimant also contends that he should be relieved of his ongoing child support obligation because the $80 to be paid each month for his daughter's support is more than offset by the Child's Insurance Benefits she receives on his earnings record.

Section 459 of the Act provides, in pertinent part, that Social Security benefits may be garnished to enforce an individual's legal obligation to provide child support or alimony.

Section 1612(a)(2)(B) of the Act and §416.1121(a) of Regulations No. 16 provide that Social Security benefits and veteran's pensions constitute unearned income. The various exclusions from unearned income are contained in section 1612(b) of the Act and §416.1124 of Regulations No. 16.

Neither the law nor the regulations provide for the reduction of income because of garnishment. Since the amount of the claimant's Social Security benefits before garnishment constitutes unearned income, he is ineligible for SSI benefits because of his excess income.

Part IB
Rulings Based on Program Policy Statements

(Previously Published as PPS-68) **SSR 82-39**

TITLES II AND XVI—USE OF TRUST OR ESCROW ACCOUNTS IN COLLECTION OF ATTORNEY FEES

PURPOSE: To state the policy on the use of trust or escrow accounts in collecting attorney fees for representation before the Social Security Administration (SSA).

CITATIONS (AUTHORITY): Sections 206(a), 207, and 1631(d)(2) of the Social Security Act; Section 413(b) of the Black Lung Benefits Act (part B of title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended); Regulations No. 4, sections 404.1720 through 404.1740; Regulations No. 10, sections 410.686b through 410.687a; Regulations No. 16, sections 416.1520 through 416.1540.

PERTINENT HISTORY: Legal organizations and individual attorneys have asked whether the use of trust or escrow accounts as a means of collecting attorney fees in connection with Social Security and black lung claims is consistent with the fee provisions of the law and regulations.

As a condition for undertaking representation, some attorneys solicit from Social Security or black lung claimants a deposit of money in a trust or escrow account as a means of assuring payment of the attorney's fees. The claimant may be asked to place funds into a trust or escrow account at the commencement of representation on a noncontingency fee basis, or in connection with a contingency fee agreement. In title XVI claims especially, some agreements may call for the claimant to deposit the first benefit check into a trust or escrow account pending approval of a fee by the Social Security Administration.

In regard to title II, title XVI, and black lung claims, the law provides that the Secretary may, by "rule and regulations, prescribe the maximum fees which may be charged" for services performed in connection with such claims, and that any agreement violating that rule or regulation would be void. The law also prohibits the charging or collecting of a fee, directly or indirectly, in excess of the maximum fee prescribed by the Secretary.

In certain cases the term "fees which may be charged" could be interpreted to include any amounts exacted by an attorney from a claimant's property, whether by way of a retainer, deposit in a trust or other escrow account, etc. If, however, the exaction is no more than security for the payment of a potential debt, it should not be considered a "fee." For example, a sum deposited under a trust or escrow agreement, which the claimant willingly entered into, could not legally be characterized as a "fee" if the agreement explicitly states that any money in excess of the fee authorized by SSA will be returned to the claimant when SSA approves a fee or when the claimant pays the attorney an amount SSA approves as a fee.

Applicable to title II, title XVI, and black lung benefits, the law provides that: "The right of any person to any future payment under this title shall not be transferable or assignable, at law or in equity . . ." This provision prohibits payment directly by SSA to a transferee or assignee of the claimant or someone else on his or her behalf. However, this provision does not preclude a claimant from using the benefits after receipt, any more than it precludes a claimant from using any other personal property as he or she sees fit. Thus, the placement of a claimant's funds (whether from benefit payments or other sources) into a trust or escrow account prior to and contingent upon SSA's authorization of a fee for the attorney's services is not a transfer or assignment within the meaning of the law.

Beyond these considerations, the fee provisions of the law that apply to title II and black lung claims differ significantly in one respect from the provisions applicable in title XVI claims. In title II and black lung cases, to assure that the claimant's attorney will be paid at least a part of the fee SSA approves, the law requires SSA to directly pay the attorney the authorized fee (up to a statutorily prescribed limit) out of the claimant's past-due benefits. In title XVI claims, there is no such statutory authority which could serve to encourage attorney representation. Thus, establishment of escrow and trust accounts, under agreements willingly entered into, is a mechanism that may encourage representation of claimants in title XVI claims, where otherwise the prospect of attorney representation would not exist.

As noted above, in title II and black lung claims, the law mandates that SSA will directly pay to an attorney the amount of the authorized fee (up to the prescribed limit) out of the claimant's past-due benefits. In cases where a title II or black lung claimant and his or her attorney have entered into a trust or escrow account agreement, the money deposited in the trust or escrow account may have been paid over to the attorney, in accordance with such agreement, after SSA's award of benefits to the claimant but before direct payment of the authorized fee out of past-due benefits. Were SSA to make direct payment to the attorney out of past-due benefits without taking into account the money paid to the attorney out of the trust or escrow account, it would be highly probable that the attorney would have "collected" a total fee in excess of the fee authorized by SSA, and thus find himself in violation of the fee provisions of the law and regulations. Therefore, while the law mandates direct payment of attorney fees in title II and black lung cases, that mandate need not be construed so rigidly as to force SSA to make a fee payment when it is known that that payment, when added to monies already collected, would place an attorney in violation of the law and SSA's own regulations.

POLICY STATEMENT: Consistent with Social Security law and regulations, an attorney may solicit from Social Security and black lung claimants whom he or she represents before SSA a deposit of money into a trust or escrow account as a means of assuring payment of the fee for services in connection with such representation; *provided that*:

a. the claimant willingly entered into the trust or escrow agreement and willingly deposited the money in the trust or escrow account; and
b. none of the money in the account is paid over to the attorney unless and until SSA has authorized a fee for the attorney, and then only in an amount up to, but not exceeding, the authorized fee; and
c. any funds in the account in excess of the authorized fee will be refunded promptly to the claimant.

At the time the attorney petitions for a fee, the amount of money held in the trust or escrow account must be disclosed to SSA.

In title II and black lung cases, when the amount authorized by SSA as an attorney's fee is less than the total of (1) the money paid to the attorney from a trust or escrow account, and (2) the amount withheld from the claimant's past-due benefits for direct payment of the attorney's fee, SSA will reduce the amount of direct payment to the attorney by the amount that such total exceeds the authorized fee.

> EXAMPLE: If the authorized fee is $1000, but the combined total of escrow payments ($600) and withheld benefits ($600) is $1200, SSA will pay $400 directly to the attorney out of withheld benefits and will release the remainder of withheld benefits ($200) to the claimant.

If the total of withheld past-due benefits and money paid from a trust or escrow account is equal to or less than the amount of the authorized fee, there will be no reduction in the amount paid to the attorney from past-due benefits.

EFFECTIVE DATE: This policy is applicable to all claims or proceedings pending before SSA as of the publication of this policy statement. In any claim or proceeding where this policy was applied prior to the publication of this policy statement, such action will be deemed to have been taken properly and in accordance with interim procedures existing at that time.

DOCUMENTATION: A copy of the trust or escrow agreement or proof that any money from the trust or escrow account in excess of the authorized fee has been returned to the claimant must be provided to SSA upon request.

CROSS-REFERENCES: OHA Handbook, section 1-264(4); POMS sections GN 03920.001, GN 03920.070, GN 03970.005.

(Previously Published as PPS-69) **SSR 82-40**

TITLES II AND XVI: THE VOCATIONAL RELEVANCE OF THE PAST WORK PERFORMED IN A FOREIGN COUNTRY

PURPOSE: To clarify the adjudicative policy on considering work in a foreign country as "past relevant work" for purposes of regulations sections 404.1520(e) and 416.920(e). This program policy statement (PPS) is limited to the criteria of "the physical and mental demands" of past work, as specified in those sections.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A), 1601, and 1614(a)(3)(B) of the Social Security Act, as amended; Regulations No. 4, sections 404.1505(a), 404.1520(e) and (f), 404.1545, 404.1561, and 404.1566; Regulations No. 16, sections 416.905(a), 416.920(e) and (f), 416.945, 416.961, and 416.966.

PERTINENT HISTORY: To be found disabled within the meaning of the law, a claimant (other than a widow(er) or surviving divorced spouse under title II or a child under title XVI of the Social Security Act) must have a medically determinable physical or mental impairment(s) which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months and which is of such severity that he or she is not only unable to do his or her previous work but cannot, considering his or her age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area of the claimant's residence, a specific job vacancy exists, or the claimant would be hired if he or she applied for work.

The regulations provide a sequential evaluation process. The fourth step in evaluating disability concerns the claimant's ability to do past relevant work. Sections 404.1520(e) and 416.920(e) of the regulations provide: "*Your impairment must prevent you from doing past relevant work.* If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment, we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled."

When the claimant's past work was performed within the U.S. national economy, the "kind of work" the claimant did and its physical and mental demands are ordinarily verifiable with employers and can usually be identified in such publications as the U.S. Department of Labor's *Dictionary of Occupational Titles (DOT)* and its supplements. The *DOT* provides information about the tools and machines used in an occupation; the raw materials, products, processes or services involved; the physical demands and environmental conditions; and the training time needed to achieve at least average performance. However, there is sometimes no ready and authoritative means to verify or supplement claimants' descriptions of their past jobs outside the U.S. when they are applying for disability benefits after arrival in this country.

In answer to questions about the relevance of past work performed in a foreign country, a view commonly expressed is that a foreign job is not "relevant" unless substantially similar work can be found in the U.S. economy. This view has been strongly influenced by the practice of verifying or supplementing a claimant's description of his or her past jobs with available information about work in the U.S. economy.

Such a view, however, creates some problems. It interposes a requirement that similar work must be found in the U.S. economy as a condition for determining a claimant able to do past relevant work performed in a foreign country. This elevates an element of the fifth step of the sequential evaluation process, availability of work in the national economy, to the fourth step which only deals with the claimant's ability to do his or her past work. The law does not qualify "previous work" but does specify that "other . . . work" must exist in significant numbers in the national economy. The legislative history of the statutory provisions also does not qualify "previous work," but clearly indicates that the provisions were enacted to provide guidelines "to reemphasize the predominant importance of medical factors in the disability determination."

POLICY STATEMENT: An individual is found to be under a disability only if his or her physical or mental impairment(s) is the primary reason for inability to engage in substantial gainful work activity. Factors including change of residence from one geographical area to another, lack of job openings, and employers' hiring practices are not pertinent to the decision. The proper test in the fourth step of the sequential evaluation process is whether the individual can do his or her previous work, whether in the U.S. or in a foreign economy. A job in a foreign economy need not have a counterpart in the U. S. economy, and the lack of authoritative occupational reference materials for foreign economies is not a barrier to the decision that a claimant can or cannot meet the physical and mental demands of a formerly held foreign job as he or she described it.

The relevance of past work in a foreign economy for purposes of regulations sections 404.1520(e) and 416.920(e) is no different from the relevance of past work in the U.S. economy with respect to the physical and mental demands of the particular past job. If a claimant can meet the sitting, standing, walking, lifting, manipulative, intellectual, emotional and other physical and mental requirements of a past job, he or she is still functionally capable of performing that job regardless of the fact that the individual no longer resides in the country where the past work was performed. It is only after a claimant proves that he or she is not able to do his or her previous work that the burden shifts to the Secretary to show that there is work available in the U.S. national economy which the claimant can do (the fifth and last step of the sequential evaluation process).

EFFECTIVE DATE: This policy is effective May 14, 1982, the date of final approval of this PPS.

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 0009.C, 0015, 2041, 2068, 2093, 2105.D, 2155.32, 2380.D and E, 2383.A and C, 2383.1, 2384, 2387, 2388, 2389, 3020, 3027, 3120, 3127 and 3210.

(Previously Published as PPS-67) **SSR 82-41**

TITLES II AND XVI: WORK SKILLS AND THEIR TRANSFERABILITY AS INTENDED BY THE EXPANDED VOCATIONAL FACTORS REGULATIONS EFFECTIVE FEBRUARY 26, 1979

PURPOSE: To further explain the concepts of "skills" and "transferability of skills" and to clarify how these concepts are used in disability evaluation.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act; Regulations No. 4, sections 404.1520(f), 404.1545, 404.1561, 404.1563, 404.1565, 404.1566 and 404.1568; Regulations No. 16, sections 416.920(f), 416.945, 416.961, 416.963, 416.965, 416.966 and 416.968; and Appendix 2, Subpart P of Regulations No. 4, sections 200.00(b), 201.00(e), 201.00(f), 202.00(e) and 202.00(f).

PERTINENT HISTORY: The law states that, to be found disabled, a worker must have a medically determinable physical or mental impairment(s) of such severity that he or she is not only unable to do previous work but cannot, considering his or her age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy. Skills and their transferability relate to "work experience" in the definition of disability and to people's abilities to do occupations different from those they did before becoming impaired.

Claims which require consideration of an applicant's ability to adjust to other work are addressed in the last step of the sequential evaluation process as it is explained in the regulations.

In February 1979, the regulations were amended to consolidate all policies for adjudicating disability claims in which an individual's vocational factors; i.e., age, education and work experience, must be considered in addition to the medical condition. At that time, the medical-vocational guidelines were introduced as Appendix 2 into the regulations and became binding at all levels of adjudication and appeal.

There have been some misinterpretations and misapplications of the regulations relating to determining the skill levels of jobs and whether or not skills are transferable. In addition, there is a need to clarify the definition of semiskilled work (especially in relation to unskilled work) and to more fully explain how work skills are acquired and what jobs they may be transferable to under the regulations. There also appears to be some confusion regarding the nature of the evidence necessary to support findings as to skill levels and transferability.

Policy statements on these issues will enable all components of the Social Security Administration to better understand and apply the provisions of the regulations properly and consistently.

POLICY STATEMENT: The topics discussed below expand upon the disability regulations.

1. *When transferability of work skills is at issue.* Transferability of skills is an issue only when an individual's impairment(s), though severe, does not meet or equal the criteria in the Listing of Impairments in Appendix 1 of the regulations but does prevent the performance of past relevant work (PRW), and that work has been determined to be skilled or semiskilled. (PRW is defined in regulations sections 404.1565 and 416.965.) When the table rules in Appendix 2 are applicable to a case, transferability will be decisive in the conclusion of "disabled" or "not disabled" in only a relatively few instances because, even if it is determined that there are no transferable skills, a finding of "not disabled" may be based on the ability to do unskilled work.

2. *Skills, skill levels, and their potential for being transferred to other occupations.*

   a. *What a "skill" is.* A skill is knowledge of a work activity which requires the exercise of significant judgment that goes beyond the carrying out of simple job duties and is acquired through performance of an occupation which is above the unskilled level (requires more than 30 days to learn). It is practical and familiar knowledge of the principles and processes of an art, science or trade, combined with the ability to apply them in practice in a proper and approved manner. This includes activities like making precise measurements, reading blueprints, and setting up and operating complex machinery. A skill gives a person a special advantage over unskilled workers in the labor market.

Skills are not gained by doing unskilled jobs, and a person has no special advantage if he or she is skilled or semiskilled but can qualify only for an unskilled job because his or her skills cannot be used to any significant degree in other jobs. The table rules in Appendix 2 are consistent with the provisions regarding skills because the same conclusion is directed for individuals with an unskilled work background and for those with a skilled or semiskilled work background whose skills are not transferable. A person's acquired work skills may or may not be commensurate with his or her formal educational attainment.

b. *What "transferability" is.* Transferability means applying work skills which a person has demonstrated in vocationally relevant past jobs to meet the requirements of other skilled or semiskilled jobs. Transferability is distinct from the usage of skills recently learned in school which may serve as a basis for direct entry into skilled work (Appendix 2, section 201.00(g)).

c. *Determination that a job is unskilled.* Unskilled occupations are the least complex types of work. Jobs are unskilled when persons can usually learn to do them in 30 days or less. The majority of unskilled jobs are identified in the Department of Labor's *Dictionary of Occupational Titles* (DOT). It should be obvious that restaurant dishwashers are unskilled. It may not be self-evident that other jobs can be learned in 30 days or less, such as sparkplug assembler, school-crossing guard and carpenter's or baker's helper (laborers). In these cases, occupational reference materials or specialists should be consulted. (State agencies may use vocational consultants, specialists or vocational evaluation workshops to assist in resolving complex vocational issues; and vocational experts may be consulted for this purpose at the hearing and appeals levels. In this Program Policy Statement, the term vocational specialist (VS) describes all vocational resource personnel.)

d. *Determination that a job is semiskilled and whether skills are transferable to other jobs.* Semiskilled occupations are more complex than unskilled work and distinctly simpler than the more highly skilled types of jobs. They contain more variables and require more judgment than do unskilled occupations. Even though semiskilled occupations require more than 30 days to learn, the content of work activities in some semiskilled jobs may be little more than unskilled. Therefore, close attention must be paid to the actual complexities of the job in dealing with data, people, or objects and to the judgments required to do the work.

The regulations definition of semiskilled work in regulations sections 404.1568(b) and 416.968(b) states that semiskilled jobs "may require alertness and close attention . . . coordination and dexterity . . . as when hands or feet must be moved quickly to do repetitive tasks." These descriptive terms are not intended, however, to illustrate types of skills, in and of themselves. The terms describe worker traits (aptitudes or abilities) rather than acquired work skills.

Skills refer to experience and demonstrated proficiency with work activities in particular tasks or jobs. In evaluating the skill level of PRW or potential occupations, work activities are the determining factors.

Worker traits to be relevant must have been used in connection with a work activity. Thus, in the regulations, the trait of alertness is connected with the work activities of close attention to watching machine processes, inspecting, testing, tending or guarding; and the traits of coordination and dexterity with the use of hands or feet for the rapid performance of repetitive work tasks. It is the acquired capacity to perform the work activities with facility (rather than the traits themselves) that gives rise to potentially transferable skills.

At the lower level of semiskilled work (next to unskilled) are jobs like those of a chauffeur and some sewing-machine operators. Also at the lower level of semiskilled work would be such jobs as room service waiter, in which the worker serves meals to guests in their rooms, taking silverware, linen, plates and food on a tray or cart and then removing the equipment from rooms after guests have eaten. Transferability of skills is not usually found from this rather simple type of work. When job activities are at this minimal level of skill, an adjudicator or administrative law judge (ALJ) can often, without assistance, make the determination that the worker has very little vocational advantage over an unskilled person and does not have transferable skills.

Slightly more complex, *at a higher level of semiskilled work*, are jobs like that of a nurse aide, who may also serve food to people. A nurse aide ordinarily performs other tasks which do not provide a special advantage over unskilled workers, such as dusting and cleaning rooms, changing bed linens, and bathing, dressing and undressing patients. The only duties which suggest transferable skills are those related to "nurse" rather than "aide"—taking and recording the rates of temperature, pulse and respiration; and recording food and liquid intake and output. However, these occasional or incidental parts of the overall nurse aide job, which are a small part of a higher skilled job (nurse), would not ordinarily give a meaningful vocational advantage over unskilled work. The extent of such duties, however, may vary with individual nurse aides.

On the other hand, a semiskilled general office clerk (administrative clerk), doing light work, ordinarily is equally proficient in, and spends considerable time doing, typing, filing, tabulating and posting data in record books, preparing invoices and statements, operating adding and calculating machines, etc. These clerical skills may be readily transferable to such semiskilled sedentary occupations as typist, clerk-typist and insurance auditing control clerk.

e. *Determination that a job is skilled and whether skills are transferable to other jobs.* Skilled occupations are more complex and varied than unskilled and semiskilled occupations. They require more training time and often a higher educational attainment. Abstract thinking in specialized fields may be required, as for chemists and architects. Special artistic talents and mastery of a musical instrument may be involved, as for school band instructors. Practical knowledge of machinery and understanding of charts and technical manuals may be needed by an automobile mechanic. The president or chief executive officer of a business organization may need exceptional ability to deal with people, organize various data, and make difficult decisions in several areas of knowledge.

   At a lower level of skilled work are jobs like bulldozer operator, firebrick layer, and hosiery knitting machine operator. Where the skills in (and transferability of skills from) jobs like these are at issue, occupational reference sources or a VS should be consulted as necessary.

   At the upper end of skilled work are jobs like architect, aircraft stress analyst, air-conditioning mechanic, and various professional and executive or managerial occupations. People with highly skilled work backgrounds have a much greater potential for transferability of their skills because *potential* jobs in which they can use their skills encompass occupations at the same and lower skill levels, through semiskilled occupations. Usually the higher the skill level, the more the potential for transferring skills increases. Consultation with a VS may be necessary to ascertain whether and how these skills are transferable.

3. *Documentation of skills and skill levels.*

   a. *Sources of job information.* A particular job may or may not be identifiable in authoritative reference materials. The claimant is in the best position to describe just what he or she did in PRW, how it was done, what exertion was involved, what skilled or semiskilled work acctivities were involved, etc. Neither an occupational title by itself nor a skeleton description is sufficient. If the claimant is unable to describe PRW adequately, the employer, a coworker or a member of the family may be able to do so.

      Skills, levels of skills and potential occupations to which skills from PRW may be transferred are for the adjudicator or ALJ to determine (with the assistance, when required, of a VS or occupational reference sources).

   b. *Determination of skill levels of past work.* In many cases, the skill level of PRW will be apparent simply by comparing job duties with the regulatory definitions of skill levels. This is especially true with most unskilled and most highly skilled work. Job titles, in themselves, are not determinative of skill level. Where it is not apparent, the adjudicator or ALJ should consult vocational reference sources; e.g., the DOT and its supplements. A VS is sometimes required to assist the adjudicator or ALJ in determining the skill level of past work.

4. *Application of the concept of transferability.*

   a. *How transferability is determined in general.* Where transferability is at issue, it is most probable and meaningful among jobs in which: (1) the same or a lesser degree of skill is required, because people are not expected to do more complex jobs than they have actually performed (i.e., from a skilled to a semiskilled or another skilled job, or from one semiskilled to another semiskilled job); (2) the same or similar tools and machines are used; and (3) the same or similar raw materials, products, processes or services are involved. A complete similarity of all these factors is not necessary. There are degrees of transferability ranging from very close similarities to remote and incidental similarities among jobs.

      Generally, the greater the degree of acquired work skills, the less difficulty an individual will experience in transferring skills to other jobs except when the skills are such that they are not readily usable in other industries, jobs and work settings. Reduced residual functional capacity (RFC) and advancing age are important factors associated with transferability because reduced RFC limits the number of jobs within an individual's physical or mental capacity to perform, and advancing age decreases the possibility of making a successful vocational adjustment.

b. *Medical factors and transferability.* All functional limitations included in the RFC (exertional and nonexertional) must be considered in determining transferability. For example, exertional limitations may prevent a claimant from operating the machinery or using the tools associated with the primary work activities of his or her PRW. Similarly, environmental, manipulative, postural, or mental limitations may prevent a claimant from performing semiskilled or skilled work activites essential to a job. Examples are watchmakers with hand tremors, house painters with severe allergic reactions to paint fumes, craftsmen who have lost eye-hand coordination, construction machine operators whose back impairments will not permit jolting, and business executives who suffer brain damage which notably lowers their IQ's. These factors as well as the general capacity to perform a broad category of work (e.g., sedentary, light or medium) must be considered in assessing whether or not a claimant has transferable work skills. If an impairment(s) does not permit acquired skills to be used, the issue of transferability of skills can be easily resolved.

c. *Special provisions made for transferability.* To find that an individual who is age 55 or over and is limited to sedentary work exertion has skills transferable to sedentary occupations, there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings or the industry. The same is true for individuals who are age 60 and older and are limited to light work exertion. Individuals with these adverse vocational profiles cannot be expected to make a vocational adjustment to substantial changes in work simply because skilled or semiskilled jobs can be identified which have some degree of skill similarity with their PRW. In order to establish transferability of skills for such individuals, the semiskilled or skilled job duties of their past work must be so closely related to other jobs which they can perform that they could be expected to perform these other identified jobs at a high degree of proficiency with a minimal amount of job orientation.

Generally, where job skills are unique to a specific work process in a particular industry or work setting, e.g., carpenter in the construction industry, skills will not be found to be transferable without the need for more than a minimal vocational adjustment by way of tools, work processes, work settings, or industry. On the other hand, where job skills have universal applicability across industry lines, e.g., clerical, professional, administrative, or managerial types of jobs, transferability of skills to industries differing from past work experience can usually be accomplished with very little, if any, vocational adjustment where jobs with similar skills can be identified as being within an individual's RFC.

The "Example of a hypothetical case analysis" (item 5) below illustrates a situation where carpentry skills could be considered transferable to light work for an individual of advanced age but not transferable for an individual approaching retirement age because the potential jobs identified would require more than "very little" by way of a vocational adjustment.

The regulations also provide that when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture or fishing) that they are not readily usable in other industries, jobs, and work settings, they will be considered not transferable. An adjudicator should recognize that transferability of skills is not likely for persons whose past work is unusual or isolated. Some examples are placer miners, beekeepers, or spear fishermen. However, VS assistance may be required for less obviously unusual occupations in isolated vocational settings.

5. *Example of a hypothetical case analysis.* A disability applicant worked as a carpenter in the construction industry. As described by the claimant, his job was medium work in terms of the exertional level and skilled work in terms of job complexity. The skilled work functions performed by the claimant in his carpentry job included the study of blueprints, sketches or building plans for information needed in constructing, erecting, installing and repairing structures and fixtures of wood, plywood and wallboard, using saws, planes and other handtools and power tools.

   The applicant was found to be unable to do his PRW because of a cardiovascular impairment with an RFC which prevents medium exertion. There are no other impairments which might cause additional functional limitations and interfere with the transferability of his carpentry skills.

   A decisionmaker in a State agency or in the Office of Hearings and Appeals finds that the former carpenter now has the RFC for at least a full range of light work exertion and that he is age 57, not yet close to retirement age (the age group 60-64 as defined in the regulations). The adjudicator as the finder of fact or the VS as the provider of evidence may be unable to identify closely related light occupations, preferably in the construction industry.

   If unable to do so, he or she would then do further research. The

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research might show that there are several semiskilled light job possibilities in various worker trait groups and industries. For example, cabinet assembler and hand shaper are "manipulating" occupations in the furniture industry. Rip and groove machine operator is an "operating-controlling" occupation in the furniture industry. Box repairer in the wooden box industry and grader in the woodworking industry are two "sorting, inspecting, measuring and related work" occupations. All of these involve tools, raw materials and activities similar to those of the past carpentry work. The adjudicator alone or with the assistance of a VS is able to establish that the potential occupations exist in significant numbers in the national economy.

If the decisionmaker were to find that the carpenter has the RFC for a full range of light work exertion but (to change one fact in the example) is closely approaching retirement age, the provision in section 202.00(f) of Appendix 2 requiring little, if any, vocational adjustment would apply. Under the circumstances the VS could state, and the decisionmaker could find, that the claimant's carpentry skills cannot be transferred with very little, if any, vocational adjustment required in terms of tools, work processes, work settings or the industry.

Should the decisionmaker find that the former carpenter, at any age, is now limited to sedentary work exertion, he or she would most likely find few occupations performed in the seated position which utilize the specific work skills learned and used in construction carpentry and may be unable to find transferability.

6. *Findings of fact in determinations or decisions involving transferability of skills.* When the issue of skills and their transferability must be decided, the adjudicator or ALJ is required to make certain findings of fact and include them in the written decision. Findings should be supported with appropriate documentation.

When a finding is made that a claimant has transferable skills, the acquired work skills must be identified, and specific occupations to which the acquired work skills are transferable must be cited in the State agency's determination or ALJ's decision. Evidence that these specific skilled or semiskilled jobs exist in significant numbers in the national economy should be included (the regulations take administrative notice only of the existence of unskilled sedentary, light, and medium jobs in the national economy). This evidence may be VS statements based on expert personal knowledge or substantiation by information contained in the publications listed in regulations sections 404.1566(d) and 416.966(d). It is important that these findings be made at all levels of adjudication to clearly establish the basis for the determination or decision for the claimant and for a reviewing body including a Federal district court.

EFFECTIVE DATE: Final regulations expanding the vocational factors regulations were published in the *Federal Register* on November 28, 1978, at 43 FR 55349, effective February 26, 1979. They were rewritten to make them easier to understand and were published on August 20, 1980, at 45 FR 55566. The policies in this PPS also became effective on February 26, 1979.

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 2093, 2105.D, 2380.E, 2382, 2384, 2387.B.4 and 5, 2388.B and C, 2389, 2390, 2863 and 3027.C.2.

(Previously Published as PPS-66) **SSR 82-42**

TITLE II: INTERNATIONAL SOCIAL SECURITY (TOTALIZATION) AGREEMENTS—DISCLOSURE OF INFORMATION OBTAINED FROM FOREIGN COUNTRIES

PURPOSE: To state the principles for disclosing information obtained from a foreign country in connection with administering an international Social Security agreement.

CITATIONS (AUTHORITY): 5 U.S.C. 552; Sections 1106(a) and 233 of the Social Security Act; and 20 C.F.R., Parts 401, 422 (Subpart E) and Part 404 (Subpart T).

PERTINENT HISTORY: Section 317 of the Social Security Amendments of 1977 (Public Law 95-216) added section 233 of the Social Security Act. It authorizes the President to enter into bilateral agreements with other countries to (1) provide totalization arrangements between the United States Social Security system and the social security system of the other country, and (2) eliminate dual Social Security coverage and taxation for work covered under both Social Security systems. The pertinent history of this provision was previously published in Program Policy Statement (PPS) No. 51.

ISSUES AND OPTIONS: The basic policies relating to totalization agreements were published in PPS No. 51 and PPS No. 56, and later as Social Security rulings (SSR 80-15 and SSR 81-8). This PPS addresses the issue of disclosure of information obtained by the Social Security Administration (SSA) from foreign countries in the course of administering these agreements.

International Social Security agreements are designed, in part, to prevent gaps in Social Security protection for people who work at various times under the U.S. program and the program of another country. Once an agreement takes effect, SSA must take, develop and adjudicate claims for United States totalized benefits based on a claimant's work history in both the United States and the other country. In order to assist SSA in determining a claimant's eligibility for and the amount of totalized U.S. benefits, the other country party to an agreement may provide SSA with certain information in its possession.

For purposes of this PPS, the term "information received from a foreign country" means personal information SSA receives from the records maintained by the government of a foreign country which is party to an international Social Security agreement with the U.S. This information may include personal information on the claimant's earnings in the other country, such as the amount of earnings on which Social Security contributions were made to the foreign system, the periods of work in the other country, and so on. The term does not include information the foreign country receives on behalf of SSA and forwards to SSA. For example, if an individual files a claim for U.S. benefits with a foreign country, any information on the application and any evidence or documents submitted by the claimant would not be considered information received from a foreign country; rather, it would be treated as if it were initially received by SSA directly from the claimant.

When SSA receives information from a foreign country in the course of administering an international agreement, that information becomes part of SSA records. As part of SSA records, it is subject to U.S. law governing privacy and disclosure. In determining whether to disclose information received from a foreign country, SSA will apply the rules set out in 20 CFR Part 401. SSA will disclose personal information when specifically required by Federal statutes and will not disclose personal information whenever disclosure is specifically prohibited by Federal statutes. See 20 CFR 401.205 and 401.210. Whenever disclosure is neither required nor prohibited by Federal law, SSA will look to the Freedom of Information Act (FOIA) principles to decide on disclosure, even if the FOIA does not specifically apply (e.g., whenn information is requested by a Federal agency). See 20 CFR 401.215 and 401.300. This assures uniform criteria for evaluating all disclosure questions, and in applying these principles, SSA will not disclose the information if its release would constitute a clearly unwarranted invasion of personal privacy. If the privacy interests served by withholding the information outweigh the public interests served by disclosure, SSA will not disclose.

In applying FOIA principles to information received from a foreign country SSA will take into account the public interest involved in the conclusion and administration of international Social Security agreements. Any routine disclosure of information received from a foreign country could undermine that country's confidence in the U.S. enforcement of the agreement and thus could jeopardize its effective administration. Also, if SSA routinely disclosed this information, countries with stringent privacy and disclosure laws may hesitate to enter into Social Security agreements with the U.S. and thus impede implementation of the totalization statute. The U.S. benefits from international Social Security agreements because they improve the protection afforded U.S. citizens and residents who have worked in other countries. In addition, the agreements eliminate any dual coverage and taxation of U.S. employers and their U.S. employees working in a country party to an agreement. Therefore, by not disclosing information received from a foreign country, which would result in a clearly unwarranted invasion of personal privacy, SSA will serve the public interest by assuring the effective implementation of international Social Security agreements.

In most instances, U.S. law will protect information received from a foreign country to the same extent that it protects information received from a U.S. source. However, the protection afforded U.S. Federal tax return information under the Internal Revenue Code (26 U.S.C. 6103), as amended by the Tax Reform Act of 1976, does not extend to similar tax-related information received from a foreign country, unless it is obtained by the Treasury Department for a U.S. Federal tax purpose. Thus, if a foreign country provides SSA with foreign tax-related information, that information would not be protected by the Internal Revenue Code. In affording protection to U.S. tax return information, Congress recognized that this information is of a highly sensitive and personal nature and its disclosure could lead to an unwarranted invasion of individual rights and privacy. The fact that this type of information may have come from a foreign country does not change its personal and sensitive nature. Therefore, SSA will protect the privacy of this information to the extent it legally can by applying FOIA principles. For example, under 5 U.S.C. 552(b)(6), information is exempt from the mandatory disclosure provisions of the FOIA if such disclosure would represent a clearly unwarranted invasion of privacy. Whether or not the disclosure would be a clearly unwarranted invasion of privacy is a decision to be made by SSA. Considering the great sensitivity of U.S. tax information and the scope of its protections under U.S. law, SSA may conclude that disclosure of similar foreign tax information would constitute a clearly unwarranted invasion of personal privacy.

POLICY STATEMENT: Personal information received by SSA from a foreign country in connection with the administration of a Social Security agreement between the U.S. and that country will be accorded the same protection as other sensitive personal information in the records of SSA.

When disclosure is specifically required by Federal statutes, personal information will be disclosed. When disclosure is specifically prohibited by Federal statutes, personal information will not be disclosed. When disclosure is neither specifically required nor prohibited by Federal statutes, SSA will apply the principles of the FOIA in determining whether to disclose information received from a foreign country, and will consider the public interest in maintaining the confidentiality of the information in order to protect the effective implementation of the agreement. Accordingly, the confidentiality of personal information received by SSA from a foreign country, including tax related information, will be safeguarded in accordance with the principles embodied in the FOIA, particularly 5 U.S.C. 552(b)(6).

EFFECTIVE DATE: These policies are effective November 1, 1978 the effective date of the first international Social Security agreement.

CROSS-REFERENCES: Claims Manual chapter 3700, Program Operations Manual System, Part 02, Chapter 033; PPS No. 51 (Social Security Ruling No. 80-15), Title II: International Social Security (Totalization) Agreements; PPS No. 56 (Social Security Ruling No. 81-3) Title II: International Social Security (Totalization) Agreements-Miscellaneous Provisions.

Part II
Changes in Law and Regulations

REGULATIONS SSR 82-II-II

The following amendments and additions under titles II and XVI of the Social Security Act have been published in the Federal Register:

A. REGULATIONS NO. 4—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE (20 CFR PART 404).
Subpart D—Amendments to this subpart were published in the Federal Register (47 FR 12161) on March 22, 1982.

These regulations provide widower's benefits to a widower who remarried before age 60 if the marriage terminated before the time of application, and to surviving divorced husbands. They reflect court decisions which prevent implementation of two gender-based distinctions in the Social Security Act.

B. REGULATIONS NO. 16—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED (20 CFR PART 416).

1. Subpart B—Amendments to this subpart were published in the Federal Register (47 FR 15319) on April 19, 1982.

   These regulations implement sections 201(a) and (b) of Pub. L. 96-265, which provide, in part, for the continuation of Supplemental Security Income (SSI) benefits and eligibility for Medicaid for certain severely impaired SSI recipients who work. States which elect to do so may augment the cash benefits with State supplementary payments. The regulations also provide for retaining eligibility status for Medicaid for certain of these individuals who become ineligible for SSI cash benefits because of their earnings.

2. Subpart K—Amendments to this subpart were published in the Federal Register (47 FR 13792) on April 1, 1982.

Revises the rules on what is included as income in the SSI program by providing that unearned income includes amounts withheld from another program benefit to recover an overpayment.

Part III
Items of General Interest

New and Revised Pamphlets SSR 82-III-I

The following new and revised booklets and pamphlets explaining various aspects of the retirement, survivors, disability, and supplemental security income provisions of the Social Security Act, as amended, and of the black lung provisions, have become available for distribution. Single copies of these and other leaflets and booklets are available without cost at any Social Security office. Information on quantity purchases may be obtained from that office or from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

1. Social Security and Your Household Employee. SSA Pub. No. 05-10021, January 1982.
   Some important facts you need to know if you hire a maid, cook, cleaning lady, gardner, babysitter, or other household help.

2. Your Social Security. SSA Pub. No. 05-10035, February 1982.
   A revision of the popular booklet explaining how you earn Social Security protection, the kinds of benefits you and your family can get, how Social Security is financed, and other useful information.

3. A Brief Explanation of Medicare. SSA Pub. No. 05-10043, March 1982.
   A leaflet which explains how you get Medicare protection and how its two parts fit together to help you pay for a wide range of health services.

4. Your Medicare Handbook. SSA Pub. No. 05-10050, January 1982.
   A revision of the booklet which explains what Medicare is and how it works. The handbook tells you whether the services you need are covered by Medicare and how much Medicare can pay.

5. Thinking About Retiring? SSA Pub. No. 05-10055, January 1982.
   This leaflet answers many questions about Social Security and retirement. Designed as an aid to retirement planning.

6. How Work Affects Your Social Security Checks. SSA Pub. NO. 05-10069, January 1982.

A leaflet which explains the earnings test which Social Security uses to measure the affect of your working on your benefit checks.

7. Your Social Security Rights and Responsibilities—Retirement and Survivors Insurance. SSA Pub. No. 05-10077, January 1982.

A booklet which explains to beneficiaries how they can help keep their checks coming on time every month and in the right amount, and how to report important changes.

8. Social Security Benefits—Let's Talk Dollars and Sense—for State and Local Groups. SSA Pub. No. 05-10108, February 1982.

This leaflet presents examples of the monthly Social Security benefits payable when a State worker becomes disabled, dies, or retires.

9. Medicare Coverage of Kidney Dialysis and Kidney Transplant Services. (A Supplement to "Your Medicare Handbook.") SSA Pub. No. 05-10128, January 1982.

This supplement to the above Handbook (see item 4) explains the special rules for Medicare coverage and payment of kidney dialysis and transplant services.

10. Your Social Security Rights and Responsibilities—Disability Benefits. SSA Pub. No. 05-10153, March 1982.

A booklet written for disability beneficiaries which explains the prompt reporting of certain changes, the periodic review of their claim, and the special work rules which apply to the disabled.

11. How Recent Changes in Social Security May Affect You. SSA Pub. No. 05-10314, January 1982.

A leaflet explaining the changes made to the Social Security Act in 1981.

☆U.S. GOVERNMENT PRINTING OFFICE: 1982-361-184:203

SS-191

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Rulings

Social Security Rulings

On Federal Old-Age,
Survivors, Disability,
Supplemental Security Income,
and Black Lung Benefits

OCTOBER 1982

SSR 82-43 to SSR 82-69

Department of Health
and Human Services
Social Security Administration
Office of Operational Policy and Procedure
SSA Pub No. 65-002
I. C. N. 958381

HE3.44:

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Preface

Social Security Rulings (the SSR) is published under the authority of the Commissioner of Social Security and makes available to the public a series of precedential decisions relating to Federal old-age, survivors, disability, supplemental security income, and black lung benefits programs. All reference to individual or specific businesses involved have been avoided so as not to disclose confidential information, unless already a matter of public record, as in a Federal court decision.

The SSR is based on case decisions, policy statements, decisions of the administrative law judges and the Appeals Council, opinions of the Office of the General Counsel, Commissioner's decisions, Federal court decisions, and other interpretations of the law and regulations. Once published, a ruling is binding on all components of the Social Security Administration in accordance with section 422.408 of Social Security Regulations No. 22 (20 CFR Part 422). Rulings do not have the force and effect of the law or regulations but are to be relied upon as precedents in determining other cases where the facts are basically the same. A ruling may be superseded, modified or revoked by later legislation, regulations, court decisions, or rulings.

Citations of a Social Security Ruling may be made by reference to the ruling number and the issue in which it appears. For example, ruling number one for 1980 would be cited as SSR 80-1 (Jan. 1980), or SSR 80-1 (C. E. 1980) if the annual Cumulative Edition has been published. Rulings based on court decisions are identified by a suffix "c" (such as SSR 80-1c), and rulings based on a decision of the Appeals Council of the Office of Hearings and Appeals are identified by the suffix "a" (such as SSR 80-1a).

All references to sections of law relate to sections of the Social Security Act, as amended, unless otherwise specified. All references to regulations, unless otherwise specified, are to Social Security Regulations Nos. 1, 4, 10, 16 and 22. These appear in title 20 of the Code of Federal Regulations as Parts 401, 404, 410, 416 and 422. The Code, revised as of April 1982, is available through the U. S. Government Printing Office at a subscription price of $615 per year. New and amended regulations are irst printed in the *Federal Register*; individual copies may be purchased or $1.50 (Annual Subscription rate is $300).

The SSR is published quarterly—subscription price is $7.50 a year $1.90 additional for foreign mailing); individual copies cost $2.25. An nnual Cumulative Edition (formerly entitled the "Cumulative Bulletin") is published at the close of each calendar year reproducing all rulings published throughout the year which have not been superseded. The cumulatives for the two most recent years are available for sale from the U. S. Government Printing Office. Those currently available are the 1980 edition ($5.50) and the 1981 edition ($5.50). All other cumulative editions from 1960 on are available to the public, free of charge, upon request to the Social Security Administration, Office of Regulations, 6401 Security Blvd., Baltimore, Maryland 21235.

Other related publications available for sale through the U. S. Government Printing Office are:

1. *Compilation of the Social Security Laws*—a copy of the Social Security Act, as amended, is available in a paper cover edition entitled "The Social Security Act and Related Laws." It includes parts of the Internal Revenue Code and other laws pertinent to the Social Security Act. Inquiries made to the Superintendent of Documents, U. S. Government Printing Office, will supply the user the date of the current edition available and its cost.
2. *The Social Security Handbook*—the seventh edition reflects the provisions of the Social Security Act as amended through December 31, 1981. The Handbook is intended for the use of people who want a detailed explanation of the various programs administered by the Social Security Administration, how they operate, who is entitled to benefits, and how benefits may be obtained. Copies may be purchased through the U. S. Government Printing Office at a cost of $7.50 per copy.

These publications, including materials now being prepared or planned, when published, may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. A check or money order covering the cost of the publication should accompany the order.

Part IA
Rulings and Decisions

SECTION 216(h)(1)(A) (42 U.S.C. 416(h)(1)(A)) RELATIONSHIP—PRESUMPTION OF THE VALIDITY OF THE LAST MARRIAGE

20 CFR 404.345

SSR 82-43

The claimant and the worker were ceremonially married in Mississippi in 1929. After separating in 1931, they both had two other marriages. The worker was still married to his third wife and living with her in Kansas when he died in 1967. When the claimant applied for widow's insurance benefits (WIB) on the worker's earnings record, she alleged that she and the worker were never divorced. Although a divorce decree was not found in the known residences of either party, the record contains no evidence of the worker's whereabouts between 1931 when he separated from the claimant and 1954 when he married his third wife. Under section 216(h)(1)(A) of the Social Security Act (the Act), the laws of Kansas apply in determining whether the claimant is the worker's widow. Under Kansas law, where the parties prove more than one marriage of an individual, there is a presumption that the prior marriages were dissolved by death or divorce before the last marriage was contracted. The burden of overcoming that presumption is on the party attacking the validity of the last marriage. *Held*, if more specific information as to where the worker may have lived from 1931 to 1954 is unobtainable, then, under Kansas law, the presumption of the validity of the worker's latest marriage is not rebutted, and the claimant is not his widow. *Further held*, if the information is obtained and a search of the divorce records of the places the worker lived fails to reveal evidence of divorce, then, under Kansas law, the presumption of the validity of the worker's latest marriage is rebutted, and the claimant is his widow.

The claimant applied for WIB on the worker's earnings record. They were ceremonially married in Mississippi on January 13, 1929, and they separated in 1931. The claimant stayed in Mississippi, where she ceremonially married her second husband on December 2, 1940. In 1948, they separated, and in 1963, she ceremonially married her third husband in Mississippi. They separated in 1965.

The worker also had two other marriages. His second wife died in 1951, and on July 4, 1954, he ceremonially married his third wife in Topeka, Kansas. He was still married to his third wife and living with her when he died in Kansas in April 1967. They had two children.

The claimant stated that she never obtained a divorce from the worker and that she was never served with divorce papers from him. The divorce records were searched in the known residences of both parties, three counties in Mississippi and one county in Kansas, and no evidence of a divorce was found. The worker's third wife stated that her husband had once done construction work and had moved around a lot. She also indicated in her application for benefits that the worker had only one prior marriage, which ended with the wife's death in 1951. The worker's sister stated that she had not kept in close contact with her brother, but that she knew of at least three wives—the claimant, the wife who died in 1951, and the wife he married in 1954. She stated that he may have had other wives, and that she did not know if he had ever obtained a divorce.

To determine whether the claimant is the worker's legal widow, the following issues must be resolved:

> Would the State of Kansas look to Mississippi law to determine the validity of the claimant's marriage to the worker? If so, does Kansas apply Mississippi rules of evidence, under which the claimant would be estopped to deny the termination of her marriage to the worker, or would the State of Kansas follow its own evidentiary rules?

Under Mississippi law, an insured individual's undivorced wife, who enters into a bigamous marriage after separation from the insured, is estopped from denying the termination of her prior marriage and attacking the validity of a subsequent marriage of the insured. Therefore, she cannot be found to be the wife of the insured individual under section 216(h)(1)(A) of the Act.

Because the claimant was domiciled in Kansas when he died, section 216(h)(1)(A) of the Act directs that the laws of that State govern in determining whether the claimant is his widow for purposes of entitlement to WIB on his earnings record.

The general rule is that a marriage which complies with the formalities imposed in the State of celebration will be held valid elsewhere. See 52 Am. Jur 2d *Marriage* §80. Thus, Kansas would recognize a marriage validly entered into in Mississippi, but that does not mean that Mississippi law will govern the question of the continuation of that marriage, when one of the parties has left the State and established a domicile in another State. The Social Security Administration (SSA) believes that in circumstances such as those present in this case, a Kansas court would apply Kansas law in determining whether the claimant is the worker's widow. The worker resided in Kansas for at least the last thirteen years of his life. His latest marriage was contracted in Kansas in 1954, and two children were born of that marriage. He was still living with his last wife and his children when he died in 1967.

SSA has found no instances where the courts of Kansas have applied the doctrine of estoppel under the described circumstances.[1] Under Kansas law, however, where the parties prove more than one marriage of an individual, there is a presumption that the prior marriages were dissolved by death or divorce before the last marriage was contracted. See *Harper v. DuPree*, 185 Kan. 483, 345 P. 2d 644 (1959). The presumption is not conclusive, but it is one of the strongest known to the law, and the party attacking the marriage has the burden of proof. The presumption may however be rebutted by evidence that divorce records of the places where the parties lived were searched and failed to reveal evidence of a divorce.

In this case, the divorce records of three counties in Mississippi and one county in Kansas were searched, but no evidence of a divorce between the worker and the claimant was found. The file, however, contains no evidence of the worker's whereabouts between 1931 when he separated from the claimant and 1954 when he married his third wife in Topeka, Kansas. The worker's third wife even indicated that her husband had frequently moved when he was doing construction work. He had also contracted another marriage after 1931 and before 1954, but the file contains no evidence as to when or where that marriage occurred.

If more specific information as to where the worker may have lived from 1931 to 1954 is unobtainable, SSA believes it would be justified in concluding that a Kansas court would find that the presumption of the validity of the latest marriage has not been rebutted, and that the claimant is not the worker's widow. If the information is obtained and a search of the divorce records of the places the worker lived fails to reveal evidence of a divorce, SSA believes it would be justified in concluding that the presumption of the validity of the latest marriage has been rebutted, and that the claimant is the worker's widow.

---

[1] Kansas courts have applied the doctrine of estoppel where one or both parties to a marriage have obtained an invalid divorce. In those cases, it has been held that the parties are estopped to deny the validity of the divorce decree to challenge a subsequent marriage of one of the spouses. See *Perrenoud v. Perrenoud*, 480 P. 2d 749 (Kan. 1971).

SECTION 210 (42 U.S.C. 410) EMPLOYMENT—COVERAGE OF WORK FOR AMISH EMPLOYERS

20 CFR 404.1004(a) **SSR 82-44c**

U.S. v. Lee, 102 S. Ct. 1051 (1982)

The appellee, a member of the Old Order Amish who employed several other Amish to work on his farm and in his carpentry shop, failed to withhold Social Security taxes from the wages of his employees or to pay the employer's share of those taxes. After the Internal Revenue Service assessed an amount for unpaid taxes against him, the appellee made a partial payment and sued for a refund, claiming that the imposition of Social Security taxes violated the First Amendment rights of both he and his employees to the free exercise of their religion. Relying upon both the First Amendment and 26 U.S.C. 1402(g), which provides an exemption for self-employed Amish, the district court held the statutes requiring the claimant to pay Social Security taxes to be unconstitutional. On appeal, the Supreme Court noted that the exemption provided by 26 U.S.C. 1402(g) is available only to self-employed individuals and does not apply to employers or employees. As to the constitutional claim, the court held that, since accommodating the Amish beliefs under the circumstances would unduly interfere with the fulfillment of the overriding governmental interest in assuring mandatory and continuous participation in and contribution to the Social Security system, the limitation on religious liberty involved here was justified. Consequently, in reversing the district court, the Supreme Court *held* that, unless Congress provides otherwise, the tax imposed on employers to support the Social Security system must be uniformly applicable to all.

BURGER, Chief Justice:

We noted probable jurisdiction to determine whether imposition of social security taxes is unconstitutional as applied to persons who object on religious grounds to receipt of public insurance benefits and to payment of taxes to support public insurance funds. —U. S.—(1981). The District Court concluded that the Free Exercise Clause prohibits forced payment of social security taxes when payment of taxes and receipt of benefits violates the taxpayer's religion. We reverse.

Appellee, a member of the Old Order Amish, is a self-employed farmer and carpenter. From 1970 to 1977, appellee employed several other Amish to work on his farm and in his carpentry shop. He failed to file the quarterly social security tax returns required of employers, withhold social security tax from his employees or pay the employer's share of social security taxes.[1]

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[1] The Social Security Act and its subsequent amendments provide a system of old age and unemployment benefits. 26 U. S. C. § 3101 *et seq*. These benefits are supported by various taxes, including, relevant to this appeal, the Federal Insurance Contributions Act (FICA) and the Federal Unemployment Tax Act (FUTA) tax. FICA is a tax paid in part by employees through withholding, 26 U. S. C. § 3101, and in part by employers through an excise tax. 26 U. S. C. § 3111. FUTA is an excise tax imposed only on employers. 26 U. S. C.

In 1978, the Internal Revenue Service assessed appellee in excess of $27,000 for unpaid employment taxes; he paid $91—the amount owed for the first quarter of 1973—and then sued in the United States District Court for the Western District of Pennsylvania for a refund, claiming that imposition of the social security taxes violated his First Amendment Free Exercise rights and those of his Amish employees.[2]

The District Court held the statutes requiring appellee to pay social security and unemployment insurance taxes unconstitutional as applied. The court noted that the Amish believe it sinful not to provide for their own elderly and needy and therefore are religiously opposed to the national social security system.[3] The court also accepted appellee's contention that the Amish religion not only prohibits the acceptance of social security benefits, but also bars all contributions by Amish to the social security system. The District Court observed that in light of their beliefs, Congress has accommodated self-employed Amish and self-employed members of other religious groups with similar beliefs by providing exemptions from social security taxes. 26 U. S. C. § 1402(g).[4] The court's holding was based on both the exemption statute for the self-employed and the First Amendment; appellee and others "who fall within the carefully circumscribed definition provided in 1402(g) are relieved from paying the employer's share of [social security taxes] as it is an unconstitutional infringement upon the free exercise of their religion."[5]

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§ 3301. Both taxes are based on the wages paid to employees, and the recordkeeping and transmittal of funds are obligations of the employer. Only FICA is collected from self-employed individuals.

In this case appellee failed to pay the employer's portion of FICA and FUTA taxes and failed to withhold his employee's contributions to FICA. An employer is liable for payment of the employe's share of FICA whether or not he withholds the required amount of the employe's contribution. 26 U. S. C. § 3102(b).

[2] Appellee also requested injunctive relief to prevent the Commissioner of Internal Revenue from attempting to collect the unpaid balance of the assessments. Under the Internal Revenue Code, injunctive relief is to be granted sparingly and only in exceptional circumstances. 26 U. S. C. § 7421(a). The District Court therefore denied injunctive relief, but noted that should the government attempt to collect the remaining payments "further Court relief could be requested." District Court Op., Reprinted in Petition for Certiorari p. 8a.

[3] Appellee indicates that his scriptural basis for this belief was: "But if any provide not . . . for those of his own house, he hath denied the faith, and is worse than an infidel." (I Timothy 5:8)

[4] 26 U. S. C. § 1402(g) provides, in part:

"(1) *Exemptions.*—Any individual may file an application . . . for an exemption from the tax imposed by this chapter if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act)."

In order to qualify for the exemption, the applicant must waive his right to all Social Security benefits and the Secretary of Health and Human Services must find that the particular religious group makes sufficient provision for its dependent members.

Direct appeal from the judgment of the District Court was taken pursuant to 28 U. S. C. § 1252.

II

The exemption provided by § 1402(g) is available only to self-employed individuals and does not apply to employers or employees. Consequently, appellee and his employees are not within the express provisions of § 1402(g). Thus any exemption from payment of the employer's share of social security taxes must come from a constitutionally-required exemption.

A

The preliminary inquiry in determining the existence of a constitutionally-required exemption is whether the payment of social security taxes and the receipt of benefits interferes with the Free Exercise rights of the Amish. The Amish believe that there is a religiously based obligation to provide for their fellow members the kind of assistance contemplated by the social security system. Although the government does not challenge the sincerity of this belief, the government does contend that payment of social security taxes will not threaten the integrity of the Amish religious belief or observance. It is not within "the judicial function and judicial competence," however, to determine whether appellee or the government has the proper interpretation of the Amish faith; "[c]ourts are not arbiters of scriptural interpretation." *Thomas v. Review Bd. of Indiana Employment Sec.*, 101 S. Ct. 1425, 1431 (1981).[6] We therefore accept appellee's contention that both payment and receipt of social security benefits is forbidden by the Amish faith. Because the payment of the taxes or receipt of benefits violates Amish religious beliefs, compulsory participation in the social security system interferes with their Free Exercise rights.

The conclusion that there is a conflict between the Amish faith and the obligations imposed by the social security system is only the beginning, however, and not the end of the inquiry. Not all burdens on religion are unconstitutional. See, *e.g.*, *Prince* v. *Massachusetts*, 321 U. S. 158 (1944); *Reynolds* v. *United States*, 98 U. S. 145 (1879). The state may justify a limitation on religious liberty by showing that it is essential to accomplish an overriding governmental interest. *Thomas, supra; Wisconsin* v. *Yoder*, 406 U. S. 205 (1972); *Gillette* v. *United States*, 401 U. S. 437 (1971); *Sherbert* v. *Verner*, 374 U. S. 398 (1963).

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[5] The precise basis of the District Court opinion is not clear. The court recognized that on its face § 1402(g) does not apply to appellee because he is not a self-employed individual. The District Court nonetheless used the language of § 1402(g) to provide an exemption for appellee. The court's decision to grant appellee an exemption, however, appears to be based on its view that the statute was unconstitutional as applied. Consequently, this Court has jurisdiction under 28 U. S. C. § 1252 to hear the appeal. See also *United States v. American Friends Service Committee*, 419 U. S. 7, 9 n. 4 (1974).

[6] This is not an instance in which the asserted claim is "so bizarre, so clearly nonreligious in motivation, as not to be entitled to protection under the Free Exercise Clause." *Thomas v. Review Bd. of Indiana Employment Sec.*, 101 S. Ct. 1425, 1431 (1981). At least one other religious organization has sought an exemption under § 1402. See also *Henson v. Com'r of Internal Revenue*, 66 U. S. T. C. 835 (1976) (member of Sai Baba denied exemption because although opposed to insurance on religious grounds, the faith did not provide for its dependent members).

B

Because the social security system is nationwide, the governmental interest is apparent. The social security system in the United States serves the public interest by providing a comprehensive insurance system with a variety of benefits available to all participants, with costs shared by employers and employees.[7] The social security system is by far the largest domestic governmental program in the United States today, distributing approximately $11 billion monthly to 36 million Americans.[8] The design of the system requires support by mandatory contributions from covered employers and employees. This mandatory participation is indispensable to the fiscal vitality of the social security system. "[W]idespread individual voluntary coverage under social security . . . would undermine the soundness of the social security program." S. Resp. No. 404, 89th Cong., 1st Sess., Pt. III, U. S. Code Cong. & Admin. News (1965), pp. 1943, 2056. Moreover, a comprehensive national social security system providing for voluntary participation would be almost a contradiction in terms and difficult, if not impossible, to administer. Thus, the government's interest in assuring mandatory and continuous participation in and contribution to the social security system is very high.[9]

C

The remaining inquiry is whether accommodating the Amish belief will unduly interfere with fulfillment of the government interest. In *Braunfeld* v. *Brown*, 366 U. S. 599, 605 (1961), this Court noted that "to make accommodation between the religious action and an exercise of state authority is a particularly delicate task . . . because resolution in favor of the State results in the choice to the individual of either abandoning his religious principle or facing . . . prosecution." The difficulty in attempting to accommodate religious beliefs in the area of taxation is that "we are a cosmopolitan nation made up of people of almost every conceivable religious preference." *Braunfeld*, 366 U. S. at 606. The Court has long recognized that balance must be struck between the values of the comprehensive social system, which rests on a complex of actuarial factors, and the consequences of allowing religiously based exemptions. To maintain an organized society that guarantees religious freedom to a great variety of faith requires that some religious practices yield to the common good. Religious beliefs can be accommodated, see e.g., *Thomas, supra; Sherbert, supra*, but there is a point at which accommodation would "radically restrict the operating latitude of the legislature." *Braunfeld, supra* at 606.[10]

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[7] The Social Security Act was enacted in 1935 to provide supplementary retirement benefits. Over the following 45 years coverage has broadened and the cost of the system has increased dramatically. See A. Abraham, et al., Federal Social Security (1979). In 1939 the Act was amended to provide insurance benefits for retired workers, auxiliaries of retired workers and survivors of deceased workers. In 1950 coverage was extended to self-employed workers and to select other employees previously excluded. In 1954 and 1956 disability benefits were added and in 1965 Medicare benefits were made available to participants in the System.

[8] National Commission on Social Security, Social Security in America's Future 5 (1981).

[9] The fiscal soundness of the Social Security has been the subject of several studies and of congressional concern. See e. *g.*, Congressional Budget Office, Paying for Social Security: Funding Options for the Near Future (1981).

Unlike the situation presented in *Wisconsin v. Yoder, supra*, it would be difficult to accommodate the comprehensive social security system with myriad exceptions flowing from a wide variety of religious beliefs. The obligation to pay the social security tax initially is not fundamentally different from the obligation to pay income taxes; the difference—in theory at least—is that the social security tax revenues are segregated for use only in furtherance of the statutory program. There is no principled way, however, for purposes of this case, to distinguish between general taxes and those imposed under the Social Security Act. If, for example, a religious adherent believes war is a sin, and if a certain percentage of the federal budget can be identified as devoted to war-related activities, such individuals would have a similarly valid claim to be exempt from paying that percentage of the income tax. The tax system could not function if denominations were allowed to challenge the tax system because tax payments were spent in a manner that violates their religious belief. (See, e.g., *Lull v. Commissioner*, 602 F. 2d 1166 (CA 4 1979), cert. denied, 444 U. S. 1014 (1980); *Autenrieth v. Cullen*, 418 F. 2d 586 (CA 9 1969), cert. denied, 397 U. S. 1036 1970). Because the broad public interest in maintaining a sound tax system is of such a high order, religious belief in conflict with the payment of taxes affords no basis for resisting the tax.

III

Congress has accommodated, to the extent compatible with a comprehensive national program, the practices of those who believe it a violation of their faith to participate in the social security system. In § 1402(g) Congress granted an exemption, on religious grounds, to self-employed Amish and others.[11] Confining the § 1402(g) exemption to the self-employed provided for a narrow category which was readily identifiable. Self-employed persons in a religious community having its own "welfare" system are distinguishable from the generality of wage earners employed by others.

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[10] See e. g., *Follett v. Town of McCormick*, 321 U. S. 573 (1944) (preacher not entitled to be free from taxes); *Murdock v. Pennsylvania*, 319 U. S. 105, 112 (1943) (same).

[11] The District Court read this as extending to the present claims. We need not decide whether the Free Exercise Clause compelled an exemption as provided by § 1402(g); Congress' grant of the exemption was an effort toward accommodation. Nor do we need to decide whether, if Congress had, as the District Court believe, intended § 1402(g) to reach this case, conflicts with the Establishment Clause would arise.

Congress and the courts have been sensitive to the needs flowing from the Free Exercise Clause, but every person cannot be shielded from all the burden incident to exercising every aspect of the right to practice religious beliefs. When followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity. Granting an exemption from social security taxes to an employer operates to impose the employer's religious faith on the employees. Congress drew a line in § 1402(g), exempting the self-employed Amish but not all persons working for an Amish employer. The tax imposed on employers to support the social security system must be uniformly applicable to all, except as Congress provides explicitly otherwise.[12]

Accordingly, the judgment of the District Court is reversed and the case remanded for proceedings consistent with this opinion.

Reversed and remanded.

The Chief Justice was joined in this opinion by Justices Brennan, White, Marshall, Blackmun, Powell, Rehnquist, and O'Connor. Justice Stevens filed a concurring opinion.

SECTIONS 203(b) and (f) and 205(a) (42 U.S.C. 403(b) and (f) and 405(a)) WORK DEDUCTIONS—DATE OF BIRTH REVISED MORE THAN FOUR YEARS AFTER INITIAL DETERMINATION—REVISION OF BENEFIT RATE

20 CFR 404.435(a) (3), 404.905, 404.988, and 404.989 **SSR 82-45a**

When the claimant applied for old-age insurance benefits (OAIB) in February 1972, he submitted evidence which established that he was born on January 5, 1907. Based on the claimant's 1978 annual report of earnings, the Social Security Administration (SSA) determined that some of the benefits paid to him for that year were subject to work deductions. The claimant appealed. In May 1979, the claimant submitted new evidence which established that his correct date of birth was January 5, 1906. Therefore, he contended that the benefits paid to him for 1978 were not subject to work deductions because he had attained age 72 in January of that year. In determining the claimant's work deductions for 1978, SSA considered two factors, the claimant's excess earnings and the months in which he had either earned more than the monthly limit in employment or rendered substantial services in self-employment. The claimant's date of birth was not a factor to be decided because that determination had previously been made when he became entitled to OAIB. The initial determination of the claimant's date of birth was made more than four years before the determination of work deductions; therefore, the initial date of birth determination could not be reopened under the rules of administrative finality. Consequently, the only factors in the 1978 work deduction determination that were subject to correction were the amount of the claimant's excess earnings and the months to which those earnings should be charged. *Held*, the date of birth initially established for the claimant was applicable for purposes of imposing work deductions for 1978. *Further held*, because of his revised date of birth, the claimant was due a benefit increase effective May 1979, the month he first questioned the initial date of birth determination.

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[12] We note that here the statute compels contributions to the system by way of taxes; it does not compel anyone to accept benefits. Indeed, it would be possible for an Amish member, upon qualifying for social security benefits, to receive and pass them along to an Amish fund having parallel objections. It is not for us to speculate whether this would ease or mitigate the perceived sin of participation.

The general issue is whether the claimant's OAIB was subject to work deductions in 1978 due to his excess earnings. The specific issue is whether the doctrine of administrative finality prohibits the claimant from being considered 72 years old in January 1978 based on new evidence presented in May 1979 where the claimant was awarded benefits based on an application filed and a determination made in 1972.

The claimant filed an application for OAIB on February 23, 1972, alleging that he was born on January 5, 1907. A date of birth of January 5, 1907, was established based on evidence submitted by the claimant, and benefits were awarded to him effective January 1972.

Following the timely submission of an annual report of earnings for 1978, SSA determined that some of the benefits paid to the claimant for that year were subject to work deductions. The claimant requested a reconsideration of that determination on June 11, 1979. He stated that he had new evidence which showed that he was born on January 5, 1906. Therefore, he contended that the benefits paid to him for 1978 were not subject to work deductions because he had attained age 72 in January of that year.

On the basis of the new evidence, SSA determined that the claimant was born on January 5, 1906. It was further determined, however, that the initial determination of the claimant's date of birth made in 1972 could not be reopened under the rules of administrative finality and that the claimant's benefits could be corrected to reflect the new date of birth effective May 1979, the month the new evidence had been received, but not retroactively. As a result, the claimant was advised that the work deductions imposed for 1978 would not be affected by the finding that he was born on January 5, 1906. The claimant requested a hearing on November 7, 1979.

The administrative law judge (ALJ) found that the rules of administrative finality barred the claimant from using the new evidence to recompute the benefit rate for the period January 1972 through April 1979, but did not bar the reopening of the determination that the claimant's benefits were subject to work deductions for 1978 based on excess earnings. The ALJ reasoned that new and material evidence had been submitted within four years of the initial determination that the claimant was subject to work deductions for 1978; that the 1978 work deduction determination was separate and distinct from the determination of the claimant's date of birth in 1972; and that the new evidence established good cause for reopening the work deduction determination. Consequently, the ALJ determined that the claimant was not subject to work deductions for 1978 because he had attained age 72 in January of that year.

Under the authority of section 205(a) of the Social Security Act, the Secretary has established by regulation that determinations and decisions of the Secretary shall become final and binding upon all parties after the lapse of a specified period of time, and may thereafter be reopened and revised only under limited circumstances.

Section 404.435(a)(3) of Regulations No. 4 provides, in part, that ". . . no matter how much a beneficiary earns in a given taxable year, no deduction on account of excess earnings will be made in the benefits payable for any month in which he or she was age 72 or over . . . ."

Section 404.905 of Regulations No. 4 provides that "[a]n initial determination is binding unless you request a reconsideration or a hearing, as appropriate, within the stated time period, or we revise the initial determination."

Section 404.988 of Regulations No. 4 provides that "[a] determination, revised determination, decision, or revised decision may be reopened—

> (a) Within 12 months of the date of the notice of the initial determination, for any reason;
>
> (b) Within four years of the date of the notice of the initial determination if we find good cause, as defined in §404.989, to reopen the case; or
>
> (c) At any time if *** (8) It is wholly or partially unfavorable to a party, but only to correct clerical error or an error that appears on the face of the evidence that was considered when the determination . . . was made . . ."

Section 404.989(a) of Regulations No. 4 provides ". . . that there is good cause to reopen a determination . . . if—

> (1) New and material evidence is furnished;
>
> (2) A clerical error in the computation or recomputation of benefits was made; or
>
> (3) The evidence that was considered in making the determination . . . clearly shows on its face that an error was made."

The Appeals Council did not concur with the ALJ's finding that the 1978 deductions determination was separate and distinct from the 1972 date of birth determination. In determining that deductions were applicable against the benefits of the claimant for 1978, SSA only considered two factors, the amount of the claimant's excess earnings and the months in which he had either earned more than the monthly limit in employment or rendered substantial services in self-employment. The claimant's date of birth was not a factor to be decided because that determination had been made when he became entitled to OAIB. The initial determination of the claimant's date of birth was made more than four years before the determination of work deductions; therefore, it could not be reopened under the rules of administrative finality. Consequently, the only factors in the 1978 work deductions determination that were subject to correction were the amount of the claimant's excess earnings and the months to which those earnings should be charged. Accordingly, the Appeals Council found that the date of birth initially established for the claimant, January 5, 1907, was applicable for purposes of imposing work deductions for 1978.

While the 1972 determination of the claimant's date of birth may not be reopened for purposes of imposing work deductions for 1978, the Appeals Council agreed that the evidence of record now supports a finding that the claimant was born on January 5, 1906, and adopted SSA's determination that the claimant's benefit rate should be recomputed based on the corrected date of birth effective May 1979, the month the new evidence of age was received by SSA. See Social Security Ruling 66-30, C.B. 1966-1970, page 358.

SECTIONS 223(d) and 1614(a) (3) (42 U.S.C. 423(d) and 1382c(a) (3))DISABILITY—AGE CRITERION OF THE VOCATIONAL FACTORS REGULATIONS—USE OF CHRONOLOGICAL AGE—CONSTITUTIONALITY

20 CFR 404.1560-404.1569 and 416.960-416.969 **SSR 82-46c**

Fogg v. Schweiker, 1st Circuit, Civ. No. 81-1232 (10/13/81)

When the claimant applied for supplemental security income and disability insurance benefits, the Social Security Administration (SSA) found that the claimant could not do his former job, but that he could do sedentary work. SSA determined, under its Medical-Vocational Guidelines, that the claimant was not disabled and denied his applications. The claimant appealed, contending that SSA had failed to consider the effects of his urinary problems on his ability to perform sedentary work. He also contended that the age criterion of the guidelines is meant to refer to "physiological age" rather than "chronological age." He based this contention on the argument that physiological age is more relevant to the determination of disability than is chronological age. He claimed that his physiological age was much more than his chronological age and that he should have been classified as an individual "closely approaching advanced age" rather than as a "younger individual." Had he been so classified, the guidelines would have directed a finding of "disabled." The claimant went on to argue that if age is meant to be chronological age, the guidelines establish an irrebuttable presumption which prevents him from introducing relevant evidence of his disability and thus unconstitutionally deprives him of due process of law. Contrary to the claimant's contention, the court found that SSA had considered the claimant's urinary problems and had concluded that he did not have a urinary tract disease. It also found no evidence that the regulations were intended to encompass physiological age rather than chronological age. Consequently, in affirming SSA's denial of the claimant's applications, the court *held* that SSA's determination that the claimant did not have a nonexertional impairment resulting from a urinary tract disease was supported by substantial evidence. The court *further held* that the age criterion in the guidelines was meant to incorporate chronological age only and thus does not refer to physiological age. The court *further held* that the use of chronological age does not prevent a claimant from introducing evidence of his or her disability and is a constitutional means of classification.

BREYER Circuit Judge:

This case is an appeal from a decision of the United States District Court for the District of Maine affirming the decision of the Secretary of Health and Human Services that the appellant, William H. Fogg, was not disabled within the meaning of 42 U. S. C. §§ 423(d)(1)(A) and 1382c(a)(3). Specifically, appellant claims that the Secretary improperly applied the Medical-Vocational Guidelines (the "guidelines") which have been adopted by the Social Security Administration in order to aid in the determination of disability in that he (1) failed to take into consideration limitations on the appellant's ability to perform sedentary work, and (2) failed to apply the age criterion in the guidelines in a flexible manner. Because we find that the Secretary properly considered appellant's nonexertional limitations, correctly applied the age criterion, and is supported by substantial evidence in his determinations of fact, we affirm the decision below.

I

William H. Fogg, a forty-six year-old resident of West Rockport, Maine, originally applied for Disability Insurance Benefits and Supplemental Social Security Income on November 15, 1976. He alleged that he had become unable to work in June, 1975, because of pains in his legs and chest and breathing problems. These claims were denied on June 18, 1977, and were not appealed. Mr. Fogg again filed applications on December 27, 1977, alleging the same onset date. These applications were denied initially and on reconsideration by the Social Security Administration. Appellant, his attorney, and a vocational expert appeared before an Administrative Law Judge ("ALJ") who considered the claim *de novo*. On March 28, 1979, the ALJ found that the appellant was not disabled. The Appeals Council denied appellant's request for review on August 17, 1979. Upon consideration of additional medical evidence submitted by appellant, on November 9, 1979, the Appeals Council found no basis for vacating its previous denial, thereby rendering the ALJ's decision the final decision of the Secretary of Health and Human Services, subject to judicial review.

Appellant filed suit in the United States District Court for the District of Maine seeking review. Both parties moved for summary judgment and oral argument was waived. The court, upon review of the administrative record and consideration of the briefs filed by the parties, held that the Secretary's decision was supported by substantial evidence and granted the Secretary's motion for summary judgment. Appellant appeals from this decision.

The Secretary's determination of no disability, the finding in dispute in this appeal, was derived by use of the Medical-Vocational Guidelines found at Appendix II to Subpart P of Part 404 of Title 20 of the Code of Federal Regulations (for Disability Insurance Benefits) and Appendix II to Subpart I of Part 416 of Title 20 of the Code of Federal Regulations (for Supplemental Security Income), enacted pursuant to the Social Security Act § 205, 42 U.S.C. § 405(a).[1] These guidelines consist of a series of rules, organized into a grid, which direct a conclusion of "disability" or "no disability" based upon the claimant's residual ability to perform, age, education, and previous work experience. Medical evidence of any impairment suffered by a claimant is considered at two stages in the determination. If the claimant has an exertional impairment, *i.e.*, a strength limitation, that evidence is considered in determining whether he had the residual work capacity to do sedentary, light, medium, heavy, or very heavy work. If a claimant has nonexertional limitations, either alone or in addition to his exertional impairments, the Secretary is directed to turn first to the grid to determine whether there can be a finding of "disability" based on exertional limitations alone. If not, the rules reflecting the individual's maximum residual strength capabilities, age, education, and work experience are to provide a framework for consideration of how much the individual's work capability is further diminished by those nonexertional limitations. In considering the effect of nonexertional limitations all of the relevant facts of the case are to be considered. Appendix II, § 200(e)(2).

In applying these guidelines, the ALJ made the following findings of facts:

> (4) The claimant has the following medically determinable impairments: Chronic obstructive lung disease with a severe obstructive component; bullous emphysema; muscular chest pain; and residuals of pelvic fracture with mild to moderate pelvic pain which can be exacerbated by activity. There is no established urinary tract or bladder disease, no evidence of peripheral vascular disease, and no evidence of any coronary disease.
>
> (5) The claimant's impairment is severe in that it significantly limits his ability to perform basic work-related functions.
>
> (6) The claimant does not have an impairment which is listed in Appendix 1 to either Subpart P of the Regulations No. 4 or to Subpart I of the Regulations No. 16, nor does the claimant have an impairment which is medically the equivalent of a listed impairment.
>
> (7) The claimant's past relevant work consists of employment as a gravel truck driver, a carpenter's helper, and an automobile dealer car preparer.
>
> (8) Despite his impairment, the claimant retains the residual functional capacity to walk up to 100 yards stopping once, to be on his feet for up to 20 minutes, to bend halfway to his toes and to lift and carry up to ten (10) pounds.

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[1] "The Secretary shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this title, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder."

> (9) Said residual functional capacity permits the claimant to perform work of a sedentary nature on a sustained basis.
>
> (10) The claimant's past relevant work required the functional capacity to perform work of more than a sedentary exertional level.
>
> (11) The claimant's impairments do prevent him from meeting the physical and mental demands of past relevant work.
>
> (12) The claimant was 43 years of age at the alleged onset and was 45 years of age at the date last insured, and was 46 at the time of hearing; each of which is defined as 'younger individual.'
>
> (13) The claimant has a limited education.
>
> (14) The claimant's past relevant work was of an 'unskilled' nature.
>
> (15) The claimant's impairment is solely exertional, in that it gives rise to strength limitations.
>
> (16) In view of the fact that the claimant's maximum sustained work capability limits him to performing work of a sedentary nature, and that the claimant was a "younger individual," has a 'limited' education and an 'unskilled' past relevant work history, Rules 201.18 (for age 45) and 201.24 (for age 43-44), Table No. 1, of the Appendix 2 to both Subpart P of the Regulations No. 4 and to Subpart I of the Regulations No. 16 directs a conclusion of 'not disabled.'

This appeal is limited to a challenge to the ALJ's application of the Medical-Vocational Guidelines in that it is contended that (1) the ALJ failed to take into consideration limitations on the appellant's ability to perform sedentary work, and (2) the ALJ failed to apply the age criterion of the grid in a flexible manner.

II

Appellant claims that his urinary problems, evidence of which was introduced at the hearing, constituted a nonexertional impairment which required the ALJ to consider the effects of those problems upon his ability to perform sedentary work. Appellant further argues that in the presence of such nonexertional limitations use of the grid alone constituted a failure to carry the burden of establishing that alternate jobs existed which appellant could perform.

The short answer to this objection is that the ALJ did consider the appellant's evidence of urinary problems and concluded that "[t]here is no established urinary tract or bladder disease," Finding No. 4, and further that "[t]he claimant's impairment is solely exertional . . . ," Finding No. 15. After reviewing the record, we believe that these conclusions were supported by substantial evidence.

The limited role of this court in reviewing these findings of fact is set out by the Social Security Act § 205(a), 42 U. S. C. § 405(a), which provides, in part, that "[t]he findings of the Secretary as to any fact, if supported by substantial evidence shall be conclusive . . . ." Thus the Secretary, as trier of fact, is charged with the duty to weigh the evidence, to resolve material conflicts in the testimony, and to determine the case accordingly. The findings of the Secretary are conclusive if supported by substantial evidence, *i. e.*, such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Richardson* v. *Perales*, 402 U. S. 389 (1971).

The evidence adduced at the hearing with regard to the claimed urinary problems was as follows. The appellant testified that he had urinary problems involving both voiding frequency and bladder incontinence. He offered evidence that in October of 1966 he had bloody urine and pain in the abdomen associated with urination. At that time he was admitted to Camden Community Hospital, Camden, Maine, where all tests including cystoscopy and bilateral retrograde pyelography indicated that the appellant's urinary tract was well within normal functioning limits. The final diagnosis was a recently passed left uretal stone.

Appellant next complained of voiding frequency in November, 1976, when he was examined by Dr. P. A. Millington. Dr. Millington did not conduct any tests of the urinary system, but diagnosed urinary frequency as secondary to a severe accident in 1973 which resulted in broken legs, broken pelvis, and urinary bladder involvement.

In January of 1978 appellant was examined by Jack McCue, M.D., who determined from X-rays that the appellant had a normal upper urinary tract, but opined that the urinary frequency and hesitancy were suggestive of prostatism. Dr. McCue urged further examination of the urinary problems by a specialist in this field.

Appellant then saw such a specialist, Dr. William E. Nuesse, a board-certified urologist, in July, 1978. Dr. Nuesse found absolutely normally functioning kidneys, normally draining uterers, and a bladder which functioned normally. Because there was no evidence of any abnormalities in his urinary tract, Dr. Nuesse felt that he was dealing with a basically healthy urinary tract. Dr. Nuesse further stated that frequent urination does not necessarily indicate a disease, but can result from psychological problems. Finally, Dr. Nuesse noted that the appellant had had no medical treatment whatsoever for his urinary problems and that many drugs which would help patients decrease their voiding frequency were available for reasonable medical treatment. Dr. Nuesse recommended against the granting of any disability prior to at least such medical treatment.

The appellant himself testified that he had significant urinary frequency problems for over six months and dating back to a year, with somewhat less frequency in the beginning, requiring him to urinate 20 to 30 times a day and five times a night. He indicated that for the prior two weeks, since his examination with Dr. Nuesse, such frequency was not necessary at all. Although the appellant testified that there was some seepage during that period, he said that his urinary frequency was approching normal; indeed claimant did not show any necessity for urination until one hour and forty-five minutes into the hearing.

On the basis of this evidence the ALJ concluded that there was no impairment resulting from urinary disorders. We think that he was supported by substantial evidence in this decision. The ALJ was entitled to rely on the evaluation and opinion of Dr. Nuesse, the only urologist who examined appellant and only physician who performed tests on his urinary system. The ALJ was also entitled to consider both his own observations of the appellant's voiding frequency and the appellant's statements that after his visit to Dr. Nuesse his urinary frequency was approaching normal. In light of this evidence and the fact that "[i]t is for the Secretary, not a reviewing court, to determine what weight to give to particular items of evidence," *Miranda* v. *Secretary of Health, Education, and Welfare*, 514 F.2d 996, 998 (1st Cir. 1975), we cannot say that the Secretary's determination that there was no nonexertional impairment resulting from urinary tract disease was not supported by substantial evidence. Thus, the ALJ did not misapply the guidelines when he failed to consider a nonexistent nonexertional impairment.

III

The appellant also claims that the ALJ erred in his failure to apply the age criterion of the grid in a flexible manner. The appellant contends that the "age" criterion of the grid is meant to refer to "physiological age" rather than "chronological age." Appellant bases this contention on the argument that physiological age is more relevant to the determination of disability than is chronological age, and further argues that if chronological age alone is considered, then the use of the age requirement creates an unconstitutional irrebuttable presumption. We believe that the ALJ correctly applied the age criterion when he considered chronological age only and that the application was constitutionally sound.

In 1975, when the appellant first applied for Disability Insurance Benefits and Supplemental Security Income, his chronological age was 43. He was chronologically 45 on Sept. 30, 1977, when his insured status for the purpose of disability benefits expired, and chronologically 46 at the time of the hearing.[2] According to the classifications established in the guidelines appellant was at all relevant times a "younger individual" in either the 18-44 or the 45-49 age bracket. For a person of appellant's residual work capacity, education, and previous work experience in either of those age brackets a finding of "not disabled" is directed by the grid. Appellant claims, however, that his physical age was much in advance of his chronological age and that he should have classified as an individual "closely approaching advanced age." Were he so classified, the grid would direct a finding of "disabled."

The appellant points to evidence of his premature aging in the record consisting of general statements to the effect that at various times he looked older than his stated age, two made by doctors and one made by a Social Security Administration official. Each of these statements reflects a visual impression of the appellant's appearance and is neither based on specific testing results nor is linked to any particular claims of resulting impairment. No reference to physiological age as such was offered at the hearing, and in his brief the appellant offers no indication of what his precise physiological age is, but merely suggests that it ought to be at least four years older than his chronological age.[3] He claims that the ALJ erred in ignoring this evidence of early aging.

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[2] Appellant's insured status for the purposes of Disability Insurance Benefits expired on September 30, 1977, and therefore he needed to be found disqualified as of or prior to that date to be eligible for disability benefits. There is no insured status requirement, however, under the Supplemental Security Income program.

It is our opinion, however, that the age criterion in the guidelines was meant to incorporate chronological age only and not to refer to physiological age. There is no evidence whatsoever that the regulations were intended to encompass "physiological age" rather than the common, well-known concept of chronological age. Physiological age is not a standard measure supported by any established scientific guidelines. It is not capable of precise or accurate determination; indeed, the appellant cannot say what his precise physiological age is, but merely contends that it must be at least fifty. Although it may be that there is such a thing as physiological age which can be roughly calculated, we believe that the use of exact years in the guidelines implies reference to a measure that is exactly determinable in years, not the inherently imprecise concept of physiological age. We are further bolstered in this conclusion by the guidelines reference to "age" in the context of a borderline situation. A "borderline situation" exists when there would be a shift in results caused by "the passage of a few days or months." 43 Fed.Reg. 55359.[4] This definition clearly contemplates a determination of age that is tied to some specific calendar date, as is chronological age. In contrast, physiological age could not be so accurately determined as to make this definition of a borderline situation meaningful. In short, we are unwilling to believe that the Social Security Agency would introduce such an imprecise and unusual concept as physiological age into their guidelines without clearly indicating the departure from chronological age.[5]

The appellant goes on to argue that if "age" is meant to be "chronological age" then the guidelines establish an irrebuttable presumption which prevents a claimant from introducing relevant evidence, *i.e.*, his physiological age, as to the ultimate issue, which is disability. Because such an irrebuttable presumption so limits him, the appellant argues that it unconstitutionally deprives him of due process of law. In support of this contention the appellant cites *Vlandis v. Kline*, 412 U.S. 441 (1973), in which the Supreme Court held that an irrebuttable presumption of nonresidency for students who began school as nonresidents was unconstitutional.

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[3] Apellant would have to have been even further in advance of his chronological age than is suggested in his brief in order to be found an individual "closely approaching advanced age" at the other relevant dates of June, 1975, when he first applied for benefits, and September 30, 1977, when his insured status for disability benefits expired.

[4] In the case of a borderline situation, the Secretary is directed to apply the guidelines flexibly to avoid dramatic shifts in results. Appellant also claims that his physiological age made him a borderline case and that the ALJ should thus have adopted a flexible approach to the grid. It is clear however that the appellant is not a borderline case within the intended meaning of the regulations as it requires a passage of at least four years, rather than "a few days or months" to place him into the higher age classification.

[5] Nor are we convinced that Congress, in referring to "age" as a factor to be considered in determining disability, meant to refer to anything other than chronological age. Had Congress purposely intended to refer to physiological age, it, too, would have signalled this departure from the expected by clearer language. Instead Congress simply noted that age was a relevant factor and accorded the Secretary broad powers to issue regulations which would take age into account as a part of disability. 42 U. S. C. § 423(d) (2). We cannot find that the Secretary exceeded his powers by contravening Congressional intent.

The *Vlandis* analysis has, however, been limited by the Court's subsequent decision in *Weinberger v. Salfi*, 422 U.S. 749 (1975). In that case the Court upheld a duration of marriage requirement for the receipt of surviving widow's and children's benefits, establishing that in the case of a Social Security classification " 'the Due Process clause can be thought to interpose a bar only if the statute manifests a patently arbitrary classification, utterly lacking in rational justification,' " 422 U.S. at 768, *quoting Fleming v. Nestor*, 363 U.S. 603, 611 (1960).

It is our opinion that the use of chronological age is not so utterly lacking in rational justification as to run afoul of the Due Process clause. In taking account of age, the Secretary has recognized "the increasing physiological deterioration in the senses, joints, eye-hand coordination, reflexes, thinking processes, etc., which diminish a severly impaired person's aptitude for learning and adaptation to a new job." 43 Fed.Reg. 55359. "[W]ork capacity does decline as age increases beyond a certain age; this is a logical and reasonable factor to be taken into account." *Stallings v. Harris*, 493 F.Supp. 956, 960 (W.D. Tenn. 1980).

Moreover, the specific use of chronological rather than physiological age is a constitutional means of classification. *Weinberger* makes it clear that the validity of a classification depends not upon whether the classifying regulation fits the purpose of the classification precisely, correctly identifying all members of the class, but rather upon the existence of a rational relation which links the classification to a reasonable end coupled with inherent difficulties in making individual determinations. 422 U.S. at 777. In this case chronological age is rationally related to those bodily changes which occur with approaching old age, albeit sooner for some people than for others. Given the inherent difficulties in defining, much less proving, physiological age on an individual basis, we think that classification by chronological age is appropriate. Such a classification does no more than impute to each member of an age bracket the average effects of aging for persons within that age bracket. That imputation may underestimate the effects of aging on some and overestimate those effects for others, yet the classification is defensible in light of the morass into which attempts to determine the physiological age of claimants would lead.

Finally, we note that contrary to the appellant's fears, this decision will not prevent a claimant from introducing evidence of his disability. A claimant is free to show any discernible exertional or nonexertional impairment. If the effects of premature aging for an individual should rise to the level of a demonstrable or measurable exertional or nonexertional impairment, there is no bar to the introduction and consideration

of evidence related to that impairment. The use of chronological a
the age criterion portion of the guidelines merely eliminates spe
tion about intangible, subtle, unmeasurable changes in the aging
ess. There is no cognizable prejudice to the appellant or to other c
ants in the elimination of such speculation.
Affirmed.

SECTIONS 216(i) and 223(d) (42 U.S.C. 416(i) and 423(d)) DISABI
INSURANCE BENEFITS—ABILITY TO PERFORM SEDENTARY WO
CONSTITUTIONALITY OF THE MEDICAL-VOCATIONAL GUIDELI

20 CFR 404.1501-404.1598 **SSR 82**

Taylor v. Schweiker, USDC, Middle District, N.C., Greensboro Divis
Civ. No. C-80-705-G (9/24/81)

When the claimant applied for disability insurance benefits, the Social Securi
ty Administration (SSA) found that the claimant could not do his former job, bu
that he could do sedentary work. SSA determined, under its Medical-Vocationa
Guidelines in Appendix 2, Subpart P of Regulations No. 4, that the claimant wa
not disabled and denied his application. The claimant appealed, objecting to th
use of the Medical-Vocational Guidelines to dictate a finding of not disabled i
his case. He argued that a vocational expert is required in all but exceptiona
cases and that the Medical-Vocational Guidelines unconstitutionally deprive him
of his due process rights. The court *held* that the Medical-Vocational Guidelines
in using the same kind of information which is available to a vocational expert
yield a uniform set of the same findings as would such an expert. The cour
further held that the Medical-Vocational Guidelines plainly appear to be a rea
sonable proxy for the expense and inconsistency associated with live testimony
from a vocational expert in each hearing. The court *further held* that the Medical
Vocational Guidelines are rationally related to the achievement of two goals
economy and consistency, which are undeniably legitimate governmental objectives.

GORDON, District Judge:

The plaintiff seeks judicial review, pursuant to § 205(g) of the So
Security Act, as amended, 42 U.S.C. § 405(g), of the final decision of
Secretary of Health and Human Services, denying him the estab
ment of a period of disability and for disability insurance benefits.

The plaintiff first filed his application on December 5, 1979, alle
that he became unable to work at 27 years of age because of joints,
back and side pain and swelling. The application was denied initi
and upon reconsideration. Plaintiff thereafter requested a hearing.
requested hearing was held on June 25, 1980 before Administrative
Judge Rufus K. Hayworth. On July 18, 1980, the Administrative
Judge rendered his decision, finding that plaintiff was not entitled
period of disability or to disability insurance benefits. The App

Council thereafter denied plaintiff's request for review. This action was timely instituted on December 31, 1980.

The entire administrative record has now been certified to the Court, and the parties have cross-moved for summary judgment. These motions will be deemed to have been made pursuant to Rule 7(b)(1), Federal Rules of Civil Procedure, seeking a judgment of the Court affirming or reversing the decision of the Secretary. (See *Torphy v. Weinberger*, 384 F. Supp. 1117, 1119 (E.D.Wis. 1974).)

The Administrative Law Judge found that plaintiff was unable to perform his past relevant work and yet retained the residual functional capacity for sedentary work. He also found that plaintiff was twenty-eight years old at the time of the hearing, that he had limited education and unskilled work experience. (Record, p. 19.) Plaintiff does not dispute any of these findings of fact.

After making his findings of fact, the Administrative Law Judge applied the "Medical-Vocational Guidelines" found in 20 C.F.R., Subpart A, App. 2. Given the set of facts he had found about plaintiff, the Administrative Law Judge found that "Rule 201.18 of Table No. 1, Appendix 2, Subpart P, of Regulations No. 4 and . . . No. 16, direct a finding of not disabled."[1] (Record, p. 19.) Because the regulations take administrative notice of the existence of jobs in the national economy for persons with plaintiff's age, education, work experience and residual capacity, the Administrative Law Judge found that they showed plaintiff's continuing ability to engage in gainful work. *See Stallings v. Harris*, 493 F. Supp. 956, 959 (W.D.Tenn. 1980); *Boyce v. Harris*, 492 F. Supp. 751, 752 (D.S.C. 1980).

Plaintiff's single objection to the ruling of the Secretary is the use of the "Medical-Vocational Guidelines" to dictate a finding of not disabled in his case. He argues that: "I. A vocational expert is required in all but exceptional cases." and "II. The grid regulations deny claimant's due process rights by imposing an irrebuttable presumption."

In its first argument, plaintiff's well-written brief relies in large part on case law within and without this circuit which antedates *Frady v. Harris*, 646 F.2d 143 (4th Cir. 1981), the Court of Appeals' most recent decision in this area. Thus, with all due respect to Judge McMillan's decision in *Williams v. Harris*, 500 F. Supp. 214 (W.D.N.C. 1980) and to the reasoning in cases outside this circuit, such as *Santise v. Harris*, 501 F. Supp. 274 (D.N.J. 1980), the Court is required to follow the apparent holding of *Frady v. Harris, supra*, insofar as it controls this case. In that case, the Court of Appeals specifically affirmed a decision holding Frady ineligible for benefits, based on his ability to perform sedentary work and the application of the regulatory grid to his situation. The

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[1] The regulation cited by the Administrative Law Judge does not fit plaintiff's case. It requires a finding of not disabled for individuals otherwise like plaintiff, but aged 45-49. The regulation properly applied to plaintiff is Rule 201.24, which also requires a finding of not disabled. Since the Court believes this mistake to be a clerical error on the part of the Administrative Law Judge, and since correction of the error does not change the issues of this case, plaintiff will be deemed to have been disqualified by Rule 201.24. *See Eaton v. Capps*, 348 F. Supp. 237, 240 (M.D.Ala. 1972).

Court held that the Secretary could properly apply "broadly based regulatory 'medical vocational guidelines' dealing with what constitutes capacity to perform and with the availability of particular types of employment." *Id.* at 145.

* * * * *

Plaintiff's second contention, that use of the regulations is an unconstitutional deprivation of property without due process of law, was not addressed by the Court of Appeals in *Frady v. Harris*; therefore, it will require this Court's special attention. Plaintiff's main claim of unconstitutionality rests on the "irrebbutable presumption" line of Supreme Court cases which begins (or so it is thought) with *Heiner v. Donnan*, 285 U.S. 312 (1932). The first case to use the terminology of "irrebuttable presumption" was *Vlandis v. Kline*, 412 U.S. 441 (1973). In striking down a Connecticut rule which declared all university students nonresidents of the state whose addresses at enrollment were outside Connecticut, the Court said:

> In sum, since Connecticut purports to be concerned with residency in allocating the rates for tuition and fees in its university system, it is forbidden by the Due Process Clause to deny an individual the resident rates on the basis of a permanent and irrebuttable presumption of non-residence, when that presumption is not necessarily or universally true in fact, and when the State has reasonable alternative means of making the crucial determination. Rather, standards of due process require that the State allow such an individual the opportunity to present evidence showing that he is a bona fide resident entitled to the in-state rates.

Id. at 452.

* * * * *

In more recent years, the opponents of the "irrebuttable presumption" doctrine seem to have the upper hand. A hard blow fell in *Weinberger v. Salfi*, 422 U.S. 749 (1975). There the Court upheld a social security regulation which defined "widow" and "child" so as to exclude persons who held the described relationships to a deceased wage earner for less than nine months. Although a three-judge district court has struck down the definition as an "irrebuttable presumption," the Court, per Justice Rehnquist, held that the definition simply states a requirement for the receipt of benefits: widows and stepchildren must have been related to the deceased wage earner for more than nine months in order to qualify for benefits as his survivors. *Id* at 772. Therefore, the Court held, the standard which the classification must pass is that of rationality.

* * * * *

Justice Rehnquist distinguished two predecessor irrebuttable presumption cases, *Stanley v. Illinois*, 405 U.S. 645 (1972), and *Cleve-*

land Board of Education v. LeFleur, supra, as concerned with specially protected individual freedoms. He did not discuss *Bell v. Burson, supra,* or *United States Department of Agriculture v. Murry, supra.* The former dealt with a Georgia provision which automatically suspended the drivers' license of an uninsured driver involved in an accident, regardless of fault. The latter dealt with a food stamp regulation barring from participation any member of a family 18 years old or older who was simultaneously claimed as a dependent by a non-eligible taxpayer. Justice Rehnquist attempted to distinguish *Vlandis v. Kline, supra,* but few commentators have regarded that effort as successful:

> In *Vlandis,* students were irrebuttably presumed to retain the same residency throughout their careers in Connecticut institutions of higher learning; in *Salfi,* certain marriages of brief duration were irrebuttably presumed to be sham arrangements. It may be, therefore, that the Court now wishes to restrict application of a strict irrebuttable presumptions approach largely to those classifications which affect recognized constitutional rights, but does not, given the case's recent vintage, wish to overrule *Vlandis* outright.

Yarbrough, The Burger Court and Unspecified Rights: On Protecting Fundamental and Not-so-fundamental "Rights" or "Interests" through a Flexible Conception of Equal Protection, 1977 Duke L.J. 143, 158.

The strong language of *Weinberger v. Salfi, supra,* the weakness of Justice Rehnquist's effort to distinguish and preserve *Vlandis v. Kline, supra,* and the speculations of commentators like Professor Yarbrough cause courts to wonder whether the "irrebuttable presumption" doctrine has any vitality at all in current constitutional jurisprudence. The Second Circuit held that after the former *Weinberger v. Salfi,* the "irrebuttable presumption" rule has merged into a simple rule of rationality which, under the Equal Protection Clause, governs all legislative classifications. *Johnson v. Lefkowitz,* 566 F.2d 866, 869 (2nd Cir. 1977); *Clayborne v. Califano,* 603 F.2d 372, 380 (2nd Cir. 1979) ("Whatever viability the above-mentioned cases retain in their respective contexts, the Supreme Court has all but ruled them inapplicable to social welfare legislation.") The Seventh Circuit has ruled that after *Weinberger v. Salfi,* the Supreme Court has tacitly abandoned the doctrine altogether. *See Trafelet v. Thompson,* 594 F.2d 623, 629-30 (7th Cir.), *cert. denied,* 444 U.S. 906 (1979). Therefore, plaintiff's argument confronts an initial difficulty in asserting the validity of the "irrebuttable presumptions" doctrine, especially in the light of recent cases which seem to discount that doctrine. *See, e.g., Usery v. Turner Elkhorn Mining Co.,* 429 U.S. 1, 22-23 (1976).

Nonetheless, if this Court assumes, as it will, that the "irrebuttable presumptions" doctrine is yet potent, the question remains: What standard of review does this strand of Due Process employ? The Court of Appeals for the Third Circuit has analyzed the irrebuttable presumptions cases in two classes, and that analysis seems applicable here. In *Malmed v. Thornburgh,* 621 F.2d 565 (3rd Cir. 1980), the Court reasoned that cases like *Stanley* v. *Illinois*, *supra*, applied an exacting standard of review to presumptions which impinged on specially protected rights. *Id.* at 575. Those cases have no bearing here, where plaintiff is not claiming any infringement on his constitutional lilberties. But the other category of cases, typified by *Vlandis* v. *Kline*, *supra*, are cases which "invalidated a classification adopted as an administrative device to serve as evidence of another classification." *Id.* at 574. Those cases, the Court said:

> should not be expanded beyond their context. They involved administrative short-cuts by which individuals were determined to be ineligible for benefits. The uitimate criteria for eligibility were unchallenged in all three cases; the challenges were to the use of proxies to prove the ultimate criterion. In each case, the Court struck down the procedure because the proxy was not reasonably related to the ultimate criterion.

Id. at 575. Therefore, the proper question for this Court as drawn from a somewhat cloudy set of Supreme Court cases, is whether the "Medical-Vocational Guidelines" employed by the Secretary offer a reasonable proxy for the testimony of a vocational expert.

As noted above, the "Medical-Vocational Guidelines" are intended to serve as administrative notice of the availability of jobs within the national economy for persons of certain age, education, work experience, and residual work capacity. The introduction to the guidelines explains how the tables are derived:

> [I]n promulgating the rules, administrative notice has been taken of the numbers of unskilled jobs that exist throughout the national economy at the various functional levels (sedentary, light, medium, heavy and very heavy) as supported by the "Dictionary of Occupational Titles" and the "Occupational Outlook Handbook," published by the Department of Labor; the "County Business Patterns" and "Census Surveys" published by the Bureau of the Census; and occupational surveys of light and sedentary jobs prepared for the Social Security Administration by various State employment agencies.

20 C.F.R., Subpart P, App. 2, § 200.00(b). In other words, the grid, using the same kind of information which is available to a vocational expert, yields a uniform set of the same findings as would such an expert, although in a tabular form. This scheme plainly appears to be a reasonable proxy for the expense and inconsistency associated with live testimony from such an expert in each hearing.

But plaintiff does not contest the manner in which the grid was designed or even its accuracy in reporting the availability of jobs for certain classes of people. He does argue that it is unreasonable to presume that a claimant is not disabled "without considering the claimant's individual characteristics." He poses the apparently hypothetical possibility of a claimant who is physically able to do sedentary work, but whose emotional or other non-exertional problems render him unemployable. The problem with this argument is that the regulations attached to the grid specifically provide that no individual with non-exertional impairments shall be presumed not disabled on the basis of the grid, but that that person's individual situation must be weighed—most usually through the aid of vocational testimony.[^] See *Id.*, § 200.00(e); 20 C.F.R. § 404.1513; *Phillips v. Harris*, 488 F. Supp. 1161, 1166 (W.D.Va. 1980). Therefore, this argument on plaintiff's behalf cannot stand.

Plaintiff also argues that the regulations are unreasonable because in one case "a single year's age difference may mean the difference between the claimant being 'disabled' or 'not disabled.'" He urges the Court to note the difference in result between Rules 201.17 and 201.23 of 20 C.F.R., Subpart P, App. 2. The former rule requires that a 45-year-old person who is illiterate with unskilled work experience and able to do sedentary work be found disabled. Under the latter rule, the same individual, at age 44, must be found not disabled. This difference in result, plaintiff asserts, is "arbitrary."

Two problems doom plaintiff's argument. First, this particular plaintiff has no standing to challenge this particular asserted irrationality. To have standing to challenge a regulation such as this, a plaintiff must allege that the specific irrational rule has actually injured him "and that he personally would benefit in a tangible way from the court's intervention." *Warth v. Seldin*, 422 U.S. 490, 508 (1975). Since plaintiff is not a 44-year-old man who is presumed not disabled by the allegedly irrational rule, he cannot raise that particular irregularity as a claim in his suit.

But more directly responsive to plaintiff's argument is the reality that whether a line is drawn in the mind of a vocational expert or through the regulatory grid, lines must be drawn to separate eligible claimants from the ineligible. The fact that plaintiff's hypothetical illiterate, inexperienced middle-aged sedentary worker crosses the line with his 45th birthday is no more irrational than the fact that a child of 17 years and 11 months may not vote in a national election. If the lines which are drawn to define eligibility are reasonable, then the hypothetical "closest possible case" avails naught in an attempt to declare the rules unreasonable. To put it another way, "almost" only counts in horseshoes, not in constitutional jurisprudence. See *Weinberger v. Salfi*, *supra* at 772-777; *Malmed v. Thornburgh*, *supra* at 577, n.18, 578 (upholding mandatory retirement for state judges at age 70). The rationale behind this regulation is clear: younger people are more hirable than older people; therefore, based on the sources noted in § 200.00(b) of 20 C.F.R., Subpart P, App. 2, the regulations draw an eligibility line at age 45 for the described individual. That is reasonable.

Plaintiff's final attack on the regulations is the claim that the grid is not rationally related to achievement of legitimate governmental goals. The government has two obvious goals in use of the grid: economy and

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[^]Under 20 CFR 404.1566(e) and 20 CFR 416.966(e), where there is an issue as to whether work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, SSA will decide whether to use the services of a vocational expert or other specialist. [ED] consistency. The two goals are undeniably legitimate governmental objectives. The best argument that plaintiff can muster against them is that the use of this grid does not achieve the same degree of economy achieved by the regulation upheld in *Weinberger v Salfi*, *supra*, and that consistency might be equal if the use of the grid were restricted to nonhearing determinations. Neither argument denies that use of the grid promotes these legitimate objectives; therefore, this last argument against the regulations must also fall.

> In summary, the Court concludes that defendant has acted within its statutory authority and has promulgated reasonable and rational regulations designed to meet Congress' desire for a more orderly, comprehensible, and uniform disability program. Plaintiff's challenge to the regulations must therefore be rejected.

Stallings v. Harris, *supra* at 961.

The factual conclusions of the Administrative Law Judge leading to the application of the administrative standards are not contested, and the use of the "Medical-Vocational Guidelines" was legally sound.

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It is therefore ordered and adjudged that the decision of the Secretary be and is hereby affirmed and the action dismissed with costs addressed to the plaintiff.

SECTIONS 216(i) and 223 (42 U.S.C. 416(i) and 423) DISABILITY—SEVERITY OF IMPAIRMENT—CONFLICTING MEDICAL EVIDENCE

20 CFR 404.1526* **SSR 82-48c**

Oldham v. Schweiker, 660 F.2d 1078 (5th Cir. 1981)

> When the claimant applied for disability insurance benefits (DIB), she alleged that she had been unable to work since February 1975, primarily because of degenerative arthritis ensuing from injuries received in a 1973 accident. When the claimant's orthopedist saw her in August 1974, he detected "early arthritic changes." Subsequently, in 1978, this orthopedist indicated that the claimant was totally disabled on or before December 31, 1975, the date she last met the disability insured status requirements, but he did not offer any clinical or laboratory findings to support his conclusory statement. The claimant also saw a general practitioner in 1974 and 1975 and a cardiovascular specialist in 1975, but neither found any abnormalities.

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*The regulations used to make disability determinations under titles II and XVI of the Social Security Act were recodified effective August 20, 1980. See 45 FR 55566-55634 (1980) (recodified in 20 CFR 404.1501-404.1598 and 20 CFR 416.901-416.996). The regulation cited in this ruling has been renumbered and rewritten as part of the recodification, but not substantively changed. See 20 CFR 404.1527.

The Social Security Administration (SSA) had the medical records reviewed by a consulting orthopedist who concluded that the claimant did not have a severe impairment. On the basis of the objective evidence of record and the consulting orthopedist's opinion, SSA determined that the claimant was not disabled on or before the relevant date. Its denial of the claimant's application was affirmed by the district court.

On appeal, the claimant contended that the opinion of her own orthopedist as a treating physician must necessarily be accorded more weight than that of a nontreating consulting orthopedist. However, the court of appeals stated that while the opinion of an examining physician is generally entitled to more weight than the opinion of a nonexamining physician, the administrative law judge is free to reject the opinion of any physician when the evidence supports a contrary conclusion, citing 20 CFR 404.1526. The court also noted that an acceptable medical opinion as to disability must contain more than a mere conclusory statement that the claimant is disabled. It must be supported by clinical or laboratory findings.

In this case, the consulting physician's opinion was not contrary to the findings of the other two physicians, both of whom had treated the claimant on numerous occasions during the year in which she allegedly became disabled, while her own orthopedist had not treated her during that year. Therefore, the court of appeals found that the Secretary was justified in accepting the opinion of a qualified consulting physician, that was supported by the evidence, and in rejecting the conclusory statement of the treating physician, that was contrary to the evidence.

Consequently, the court *held* that SSA's decision denying DIB to the claimant was supported by substantial evidence.

SCOTT, District Judge:

This action was brought pursuant to Section 205(g) of the Social Security Act, 42 U. S. C. § 405(g), to review a final decision of the Secretary denying disability insurance benefits to claimant Alice Oldham. The district court affirmed the Secretary's decision and this appeal followed.

Procedural History

In March 1973, Alice Oldham sustained serious injuries in an automobile-train collision, including a fracture of the right zygomatic arch, a fracture of the maxilla, a compound fracture of the right mandible, facial lacerations, fracture and dislocation of the right hip, comminuted fracture of the right distal femur, and multiple rib fractures. Claiming disability as a result of these injuries, Mrs. Oldham filed an initial applicatoin for establishment of a period of disability and for disability benefits in July 1973, but it was determined that she was ineligible to receive benefits at that time because she had only 15 quarters of coverage for the 40-quarter period ending March 31, 1973.[1] That determination was never appealed.

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[1] An individual is entitled to the establishment of a period of disability and to disability insurance benefits in any month only if he or she enjoys fully insured status as defined in Section 216(i) (3) and Section 223(c), *and* has had not less than 20 quarters of coverage dur-

Claimant filed her second application for establishment of a period of disability and for disability benefits February 28, 1975, alleging that she became unable to work February 12, 1975, due to the residual effect of injuries received in the 1973 accident. After the Social Security Administration, initially and upon reconsideration, again determined that claimant lacked insured status, claimant requested a hearing before an administrative law judge (ALJ). The ALJ, finding that claimant earned two additional quarters of coverage back in 1963, concluded that she was a fully insured individual through the quarter ending December 31, 1975. He was not called upon to reach the merits of Mrs. Oldham's disability claim. Since claimant last enjoyed insured status on December 31, 1975, it was necessary for her to establish that she became disabled on or before that date in order for her to qualify for disability benefits.[2]

On June 8, 1977, the Social Security Administration determined that Mrs. Oldham was not entitled to disability insurance benefits because she failed to show she was disabled on or before December 31, 1975. The same decision was reached upon reconsideration, after which Mrs. Oldham requested a hearing before an ALJ. On February 3, 1978, the ALJ entered his decision that claimant was not disabled prior to December 31, 1975, finding that she retained the functional capacity to engage in sedentary work activity. The decision was approved by the Appeals Council at which time it became the final decision of the Secretary, thereby enabling claimant to file the instant action in federal court.

The district court, in an order entered February 1, 1979, remanded the case to the Secretary, finding no substantial evidence supporting the denial of benefits. The court stopped short of reversal, however, because it was not convinced that claimant was entitled to disability benefits. Rather, the court's decision was limited to a determination that the Secretary erred in rejecting the opinion of claimant's treating physician that claimant was totally disabled on or before December 31, 1975, in the absence of any evidence to the contrary. Although the dis-

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ing the 40-quarter period ending with the quarter in which disability occurs. 42 U. S. C. § 416(i) (3); 42 U. S. C. § 423(c).

An individual is considered "fully insured" for purposes of establishing a period of disability and obtaining disability benefits when he or she has not less than one quarter of coverage (whenever acquired) for each calendar year elapsing after 1950 (or, if later, the year in which he or she attained age 21) up to the year in which disability is established. 42 U. S. C. § 414(a); 42 U. S. C. § 416(i) (3); 42 U. S. C. § 423(c).

Section 213(a) defines "quarter" as a period of three calendar months ending March 31, June 30, September 30, or December 31; and defines "quarter of coverage" as any quarter in which the individual earns $50 or more in wages. 42 U. S. C. § 413(a).

[2] Although the record establishes that claimant continued to meet the "20/40" requirement, see note 1, *supra*, until recently, she ceased to occupy the status of a "fully insured individual" at the conclusion of the last quarter in 1975. In his decision entered February 24, 1977, the ALJ found that Mrs. Oldham had a total of 24 quarters of coverage at the time she terminated her employment in February 1975. Thus, under Section 214(a), read in conjunction with Sections 216(i) (3) and 223(c), her fully insured status ended on December 31, 1975, that is, following the elapse of 24 calendar years after 1950.

trict judge found the treating physician's opinion to be a "virtually unsubstantiated conclusion," he ruled that the Secretary was not entitled to disregard it absent substantial countervailing evidence.

On remand, the ALJ determined that it was unnecessary to hold a supplemental evidentiary hearing, choosing instead to simply reevaluate the existing evidence in greater detail.[3] He adhered to the prior determination that Mrs. Oldham had failed to show that she was disabled on or prior to December 31, 1975. The Appeals Council, apparently of the opinion that the ALJ had failed to heed the message inherent in the district court's decision that additional evidence was needed, enlisted a consulting physician to review the records and express an opinion as to Mrs. Oldham's disability. This physician, Dr. Robert O. Gordon, concluded that no severe impairment was apparent from the medical records. The Appeals Council, relying upon Dr. Gordon's opinion, approved the decision of the ALJ. Claimant again petitioned the district court to reverse the decision of the Social Security Administration. On this occasion, however, the district court, satisfied by Dr. Gordon's report, affirmed the decision of the Secretary. This appeal was taken.

Summary of Medical Evidence

Claimant was 53 years old and had an 11th-grade education at the time she filed her second application for establishment of a period of disability and for disability benefits. She had worked as a cook in a hospital and as a sewing machine operator, the latter of which was her most recent employment, terminating in February 1975. Her claim for disability benefits, as noted, stemmed from injuries received in a 1973 accident in which the car she was riding collided with a train at a railroad crossing. Her alleged disability was claimed to have arisen not so much from the injuries themselves, but from degenerative arthritis ensuing from those injuries.

Mrs. Oldham testified that she is unable to perform housework, drive, or sit for longer than 30 minutes, due to the arthritic pain in her arms, legs, and back. She testified that she can dress and feed herself, but only with the help of her husband.

Subsequent to her accident, she has been treated intermittently by three physicians: Dr. Rex Harris, an orthopedic surgeon; Dr. Leroy Holt, a general practitioner; and Dr. Ira Holt, a cardiovascular specialist. In support of her disability, claimant relied primarily upon the opinion of Dr. Harris that she was disabled on or before December 31, 1975.

Dr. Harris treated claimant while she was hospitalized following the accident and saw her on several occasions in subsequent years. In a letter to claimant's attorney dated January 22, 1974, Dr. Harris, while acknowledging that Mrs. Oldham sustained serious injuries in the automobile-train collision, stated that she had "progressed quite satisfactorily" and was "doing quite well." The letter reflected that Dr Harris had last examined Mrs. Oldham October 21, 1973, at which time he concluded that all of her fractures had healed and that she was fully ambulatory. Dr. Harris stated that he did not anticipate any further surgery upon Mrs. Oldham, but noted the "possibility of degenerative arthritis" arising in her left hip. He also reported a "mild to moderate" impairment of her right knee, concluding that her motion would be restricted by a range of 10 to 15 percent.

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[3] In a letter dated August 8, 1979, counsel for claimant expressed his opinion to the ALJ that no supplemental evidentiary proceedings were necessary.

Dr. Harris next saw Mrs. Oldham on February 18, 1974, when he reported that she was experiencing "occasional" pain in her right hip. Nevertheless, the x-ray result was determined to be "OK." The range of motion in her right knee was found to be from 10 to 90 degree.

The last time Dr. Harris saw Mrs. Oldham prior to the filing of her claim for disability benefits was on August 22, 1974, at which time she complained of pain in her left hip, right knee, and right ankle. At that time, Dr. Harris detected "early arthritic changes." Dr. Harris did not see claimant again for almost three years.

On July 11, 1977, more than two years after filing her claim for disability and 18 months subsequent to the expiration of her insured status, Mrs. Oldham returned to Dr. Harris, complaining of pain in her lower back, right hip, and right knee. The pain was attributed to arthritic changes and anti-inflammatory medication was prescribed. On August 8, 1977, Dr. Harris' clinical notes reflect that claimant was improved. Claimant returned four months later, at which time Dr. Harris reported that she needed "a total knee on the right." This visit, on January 15, 1978, was the last time Dr. Harris saw Mrs. Oldham.

On January 19, 1978, in response to a request from claimant's attorney for a medical opinion concerning his client's disability, Dr. Harris sent a letter in which he expressed his opinion that Mrs. Oldham was totally disabled and that it would "probably be necessary" to have surgery performed on her right knee. Apparently, this surgery has never been undertaken. In response to a subsequent "request for medical information" on behalf of claimant's attorney, Dr. Harris, in a letter dated March 23, 1978, expressed his opinion that Mrs. Oldham ". . . was totally disabled on, or prior, to December 31, 1975." No clinical or laboratory findings were offered to support this conclusory statement.

As stated, in addition to Dr. Harris, two other physicians have treated Mrs. Oldham subsequent to her accident—Dr. Leroy Holt and Dr. Ira Holt. Although neither of these two physicians ever expressed an opinion as to claimant's disability, their medical reports are of significance in the resolution of this appeal.

Dr. Leroy Holt is a general practitioner who has treated Mrs. Oldham on numerous occasions beginning in 1956. He saw claimant twice in 1974. No specific problems were noted in his clinical records regarding these visits.[4]

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[4] Attempting to decipher the clinical notes compiled by the particular physicians involved herein has bestowed upon the Court a renewed admiration of pharmacists and others who, uncannily, are able to derive meaning from the etchings of the medical profession without great difficulty.

Dr. L. Holt treated claimant on several occasions in 1975. On February 28, 1975, claimant visited him complaining that her right side was numb. The result of a neurological examination, however, was listed as "OK." When claimant visited Dr. L. Holt on March 15, 1975, she told him that her feet had become numb. On March 29, 1975, he determined that she was "Doing Fine." On May 30, 1975, claimant reported that her legs had come back to life. Most of Mrs. Oldham's complaints to Dr. L. Holt in 1975 dealt with digestive problems. At no time during 1975, the year claimant alleges she became totally disabled, did Dr. Leroy Holt note any severe impairment or other abnormal findings.

Dr. Ira Holt is a cardiovascular specialist who treated Mrs. Oldham on numerous occasions in 1975 and 1976. He first saw her in October 1975, when claimant reported she was experiencing chest pain. This chest pain was ultimately attributed to a gallbladder problem rather than a heart condition. Although Dr. I. Holt's treatment of Mrs. Oldham focused on her chest pains, his clinical notes reflect that he examined her extremities in October 1975, but found no problems. No arthritic complaints are contained in Dr. I. Holt's records. His clinical notes pertaining to Mrs. Oldham's last two visits in 1975, and first two visits in 1976 respectively reflect that claimant was "Doing well" (November 24, 1975), "Tires easily" (December 23, 1975), "Doing well" (January 23, 1976), and "Doing fine" (April 16, 1976).

As noted earlier, following remand from the district court and the second finding by the ALJ that claimant was not disabled, the Appeals Council retained Dr. Robert O. Gordon to review the medical records and offer his opinion as to Mrs. Oldham's condition. Dr. Gordon, an orthopedic surgeon, found no support in the evidence for Dr. Harris' finding that claimant was totally disabled on or before December 31, 1975. Rather, Dr. Gordon concluded that ". . . even after the claimant developed severe arthritis of the knee, which was clearly not until 1977 or 1978, she remained capable, in my opinion, of strictly sedentary activity."

Legal Discussion

The gist of Mrs. Oldham's argument on appeal is that the district court erred in relying upon the report of a non-treating physician and rejecting the determination of a treating physician that claimant was totally disabled on or before the relevant date.

Prior to discussing the precise issue raised on appeal, it is important to take cognizance of the limited role of this Court in reviewing decisions of the Secretary pertaining to disability claims. "The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive . . . ." 42 U. S. C. § 405(g); *see Richardson* v. *Perales*, 402 U. S. 389, 390, 91 S. Ct. 1420, 1422, 28 L. Ed. 2d 842, 846 (1971); *Laffoon* v. *Califano*, 558 F. 2d 253, 254 (5th Cir. 1977). Substantial evidence is such relevant evidence as a reasonable person would accept as adequate to support a conclusion. *Richardson* v. *Perales*, *supra*, 402 U. S. at 401, 91 S. Ct. at 1427, 28 L. Ed. 2d at 852; *Warncke* v. *Harris*, 619 F. 2d 412, 416 (5th Cir. 1980). If supported by substantial evidence, the Secretary's findings are conclusive, and the reviewing court is not permitted to substitute its judgment for that of the Secretary, even if the reviewing court finds the evidence preponderates toward a wholly different finding. *Strickland v. Harris*, 615 F. 2d 1103, 1106 (5th Cir. 1980). Conflicts in the evidence, including medical opinions, are to be resolved by the Secretary, not by the courts. *Laffoon v. Califano, supra*, at 254-55.

It is also important to note that, although the Secretary's decision must be supported by substantial evidence, the burden is upon the claimant to prove disability. *Kirkland v. Weinberger*, 480 F. 2d 46, 48 (5th Cir.), *cert. denied*, 414 U. S. 913, 94 S. Ct. 255, 38 L. Ed. 2d 155 (1973); *Hart v. Finch*, 440 F. 2d 1340, 1341 (5th Cir. 1971); *Aldridge v. Celebrezze*, 339 F. 2d 190, 191-92 (5th Cir. 1964). The burden is a heavy one, so stringent that it has been described as bordering on the unrealistic. *Johnson v. Harris*, 612 F. 2d 993, 996-97 (5th Cir. 1980); *Williams v. Finch*, 440 F. 2d 613, 615 (5th Cir. 1971).

First, the claimant must show that he or she is unable to engage in any substantial gainful employment by reason of a medically determinable physical impairment which has lasted or can be expected to last for a continuous period of at least 12 months. 42 U. S. C. § 423(d)(1)(A). Additionally, it must be shown that the disability is of such severity that the claimant is not only unable to perform his or her previous work but cannot, considering his or her age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy. 42 U. S. C. § 423(d)(2)(A). This is true regardless of whether such work exists in the immediate area in which claimant resides, or whether a specific job vacancy exists, or whether the claimant would be hired if he or she applied. *Id.*

Claimant contends in this appeal that the opinion of Dr. Gordon, the consulting physician who never personally examined the claimant, did not constitute substantial evidence supporting the Secretary's denial of benefits, particularly since it was at odds with the opinion of Dr. Harris, a treating physician.

[Weight to Evidence]

The argument is that the opinion of a treating physician who has examined the claimant on a number of occasions is entitled to more weight on the question of disability than the opinion of a physician who has reviewed the medical evidence, but has never examined the patient. "All things being equal," claimant sets forth in her brief, "the report of the treating specialist/physician must be accepted on the issue of disability."

We agree with the basic tenet of claimant's argument, but, unfortunately for claimant, all things are not equal in the instant situation. It is true that the opinion of a treating physician is generally entitled to more weight than that of a non-treating physician. *Warncke v. Harris, supra*, at 416; *Strickland v. Harris, supra*, at 1109-10. In the case before us, however, Dr. Gordon's opinion that claimant was not disabled on or before December 31, 1975, is supported by the medical records of physicians who had examined claimant, including the records of Dr. Harris.

Consequently, it is Dr. Harris' opinion that is contrary to the evidence. The Secretary was justified in accepting the opinion of Dr. Gordon, a qualified reviewing physician, that was supported by the evidence, and in rejecting the conclusory statement of Dr. Harris, a treating physician, that was contrary to the evidence.

The law is clear that, although the opinion of an examining physician is generally entitled to more weight than the opinion of a non-examining physician, the ALJ is free to reject the opinion of any physician when the evidence supports a contrary conclusion. 20 C. F. R. § 404.1526 (1980).[5]

An acceptable medical opinion as to disability must contain more than a mere conclusory statement that the claimant is disabled. It must be supported by clinical or laboratory findings. *Kirkland* v. *Weinberger*, *supra*, at 49; *Laffoon* v. *Califano*, *supra* at 256.[6]

In *Warncke* v. *Harris*, *supra*, this Court affirmed the Secretary's denial of benefits despite the fact that claimant's personal physician had submitted a statement that his patient "... is unable to work indefinitely due to an arthritic condition in his shoulders." 619 F. 2d at 415. A reviewing physician had examined claimant's medical records and concluded that he retained the ability to engage in sedentary work activity.

The panel acknowledged that little weight is to be accorded to the opinion of a reviewing physician if it is contrary to the opinion of the only physician to examine the patient. 619 F. 2d at 416. Nevertheless, the Court found the treating physician's statement as to disability to be "so brief and conclusory that it lack[ed] strong persuasive weight." 619 F. 2d at 417.[7]

Claimant relies upon *Strickland* v. *Harris*, *supra*, to support her apparent position that the opinion of a treating physician always overshadows the opinion of a non-treating physician. In *Strickland*, this Court reversed the district court's order granting summary judgment in favor of the Secretary because the panel found no substantial evidence supporting the Secretary's finding that the claimant was capable of returning to one of her former occupations.[8] In denying benefits to claimant Strickland, the Secretary, as well as the district court, relied upon the report of one Dr. Wilkers, a reviewing physician for the Disability Determination Unit.

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[5] "The weight to be given such physician's statement depends on the extent to which it is supported by specific and complete clinical findings and is consistent with other evidence as to the severity and probable duration of the individual's impairment or impairments." 20 C. F. R. § 404.1526 (1980).

[6] The accuracy of this statement is supported by the legislative history of the 1967 amendments to the Social Security Act.

> Statements of the applicant or conclusions by others with respect to the nature or extent of impairment or disability do not establish the existence of disability for purposes of social security benefits based on disability *unless they are supported by clinical or laboratory findings or other medically acceptable evidence confirming such statements or conclusions.*

S. *Rep.* No. 744, 90th Cong., 1st Sess. 30, reprinted in [1967] *U. S. Code Cong. & Ad. News* 2834, 2882-83. (Emphasis added).

[7] The panel distinguished *Johnson* v. *Harris*, 612 F. 2d 993 (5th Cir. 1980), wherein a panel of this Court stated that the opinion of a reviewing physician who never examined the claimant, taken alone, would not constitute substantial evidence on which to base an administrative decision. *Id.* at 998. The record in *Johnson*, however, did not show that the opinions of the reviewing physicians were based on acceptable medical evidence. The Court remanded the case for the purpose of, *inter alia*, determining whether the reviewing physicians had in fact examined the claimant or whether they possessed "other adequate acceptable information" upon which to base their reports. *Id.*

Dr. Wilkers determined that the evidence failed to show a disabling condition lasting at least 12 months. His opinion, however, was contrary to the evidence. Of eight physicians and one psychologist who examined the claimant, Dr. Wilkers was the only one who concluded unequivocally that she was not disabled. Dr. Gilliken, claimant's personal physician, made detailed findings supporting his opinion that she was disabled. Another physician, a consultant to the Disability Determination Unit, also concluded that she was disabled. Two other physicians, while not expressing an opinion as to disability, found that claimant was suffering from melancholic depression and internal hemorrhoids. Yet another physician diagnosed the claimant as suffering from: "1. Non-healing abdominal wound 2. Bronchitis 3. Anxiety 4. Functional Gastrointestinal Distress." Claimant's therapist, an applied psychologist, stated that claimant ". . . may not be able to [work] due to her habitual unproductiveness." One Dr. Wills, a neurologist and psychiatrist, examined claimant but concluded that "I am unable to evaluate the significance of the complaints given in this history," although he did set forth his belief that claimant was exaggerating or dramatizing her condition. *Id.* at 1107.

Dr. Wilkers, the reviewing physician, based his report upon the medical observations of Dr. Gilliken and Dr. Wills. This Court was of the opinion that little weight should be accorded to Dr. Wilkers' opinion: first, because he had never treated the claimant; and second, because the opinion was based upon the report of Dr. Gilliken, claimant's personal physician, who reached a contrary conclusion as to disability and the report of Dr. Wills, an examining physician who expressly stated that he was unable to offer an opinion as to claimant's disability. In light of the overwhelming evidence supporting claimant's disability, the panel reversed the district court's summary judgment in favor of the Secretary and remanded the case for further proceedings.

The instant situation is more akin to *Warncke* than to *Strickland*. In *Strickland*, the opinion of the reviewing physician was clearly contrary to the evidence and, hence, was properly rejected. In *Warncke*, the opinion of the reviewing physician was supported by the evidence.

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[8] The ALJ had limited the inquiry to whether claimant Strickland was capable of returning to one of her former occupations. Apparently because he determined that she was so capable, he did not consider it necessary to reach the question of whether she was capable of engaging in *any* substantial gainful employment as set forth in 42 U.S.C. § 1382C (a)(3)(B) (Supplemental Security Income provisions), which parallels 42 U.S.C. § 423(d)(2)(A) (Federal Old Age, Survivors, and Disability Insurance Benefits). See text, *supra*.

Consequently, the panel remanded the case with instructions to consider claimant Strickland's ability to undertake substantial, gainful employment other than that in which she was formerly engaged

Moreover, the court did not feel compelled to attach controlling weight to a brief, conclusory statement as to disability, even where the statement was submitted by the claimant's personal physician.

Contrary to the situation in *Strickland*, the opinion of the reviewing physician in the case *sub judice* is supported by the evidence. Although Dr. Gordon's opinion is contrary to the opinion of Dr. Harris, it is not contrary to the findings of either of the Drs. Holt, both of whom treated Mrs. Oldham on numerous occasions during the relevant period. In fact, the opinion of Dr. Gordon is not even in conflict with Dr. Harris' own medical findings, as reflected in his clinical notes.

Furthermore, the conclusory nature of the medical opinion offered by Dr. Harris detracts from whatever persuasive weight it might otherwise have carried. While it is true that the opinion is consistent with his earlier finding that a "possibility of degenerative arthritis" existed, as well as with the record notation made in connection with Mrs. Oldham's August 22, 1974 visit showing "early arthritic changes," the opinion is totally devoid of any support in the way of clinical or laboratory findings. Indeed, it would be difficult to image how Dr. Harris could support his opinion with medical evidence in light of the fact that he never treated Mrs. Oldham during the year in which she supposedly became totally disabled. In fact, his opinion was offered subsequent to a period of almost three years in which he never saw claimant. As noted by Dr. Gordon in his report to the Appeals Council, the finding of only mild arthritic changes just a few months prior to the date upon which claimant alleges she became totally disabled, combined with the absence of any visits to Dr. Harris during this period, refutes a finding of severe impairment on or before December 31, 1975.

Accordingly, because the opinion of the reviewing physician is supported by the evidence, the district court was entitled to accept that opinion and reject the conclusory opinion of Dr. Harris, one of claimant's treating physicians. Thus, finding substantial evidence supporting the decision of the Secretary denying disability insurance benefits to Alice Oldham, we affirm the decision below.

Affirmed.

SECTION 1614(a)(3)(A) (42 U.S.C. 1382c(a)(3)(A)) SUPPLEMENTAL SECURITY INCOME—CONTINUANCE OR CESSATION OF A NON-GRANDFATHEREE'S DISABILITY—A RULING OF NONACQUIESCENCE

20 CFR 416.994 **SSR 82-49c**

Patti v. Schweiker, 9th Circuit, Civ. No. 80-5763 (2/18/82)

The Social Security Administration (SSA) does not acquiesce in the court's decision.

The claimant had been receiving supplemental security income (SSI) benefits as a disabled individual since 1976. In December 1977, SSA informed the claimant that her disability had ceased. After a hearing in March 1978, this determination was reversed by an administrative law judge (ALJ) and the claimant's benefits were continued. SSA then informed the claimant that her disability had ceased in April 1979, and that determination was affirmed by the district court.

The Court of Appeals, however, reversed SSA's determination. The court found that the determination of disability in 1978 gave rise to a presumption at the hearing in 1979 that the claimant was still disabled. While the opinion acknowledges that this presumption does not shift the burden of proof and the claimant still has the burden of proving her case, the court found that the presumption imposes on the Secretary the burden of going forward with evidence that the claimant's condition has medically improved or otherwise changed. Finding that there was essentially no evidence to support a conclusion that the claimant's condition had changed, the court held that SSA's determination that the claimant's disability had ceased was not supported by substantial evidence.

In essence, the court has concluded that SSA must show that an SSI recipient's condition has improved or otherwise changed before it can determine that the recipient's disability has ceased. SSA disagrees with the court's conclusion that medical improvement or other change is required in these cases.

Regardless of whether medical improvement or other change is or is not shown, under 20 CFR 416.994(b)(1), a determination of cessation is appropriate for an SSI *nongrandfatheree* if the recipient is not disabled under the Federal criteria; i.e., current medical or other evidence shows that the recipient is able to engage in substantial gainful activity.[a]

Since the claimant in *Patti* is an SSI nongrandfatheree, SSA determined that her disability ceased in April 1979 because it found, on the basis of current medical evidence, that she was capable of engaging in substantial gainful activity (i.e., she does not meet the Federal definition of disability).

As noted above, under 20 CFR 416.994(b)(1), issued in August 1980, SSA is not required to show medical improvement or other change in order to terminate SSI disability benefits. However, the final administrative decision in *Patti* was issued prior to August 1980 so that the court's decision in *Patti* was based on an administrative decision involving regulations no longer in effect. Moreover, the Court of Appeals in *Patti* did not even address either the August 1980 regulations or the earlier regulations governing when disability ceases. For these reasons (and since there are other Court of Appeals decisions which do not require a showing of improvement to terminate disability benefits), we believe that *Patti* does not provide a judicial interpretation of the disability regulations which should be followed.

Consequently, SSA *holds* that, even if current medical or other evidence does not show "medical improvement" or other change, the disability of a nongrandfathered SSI recipient is subject to cessation if such evidence shows that the recipient is able to engage in substantial gainful activity (i.e., the recipient does not meet the Federal definition of disability).

FERGUSON, Circuit Judge:

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[a] A showing of medical improvement or other change is also not required in cessation cases involving an SSI grandfatheree (see SSR 82-100 (Jan 1982).)

Plaintiff began receiving supplemental security disability benefits in 1976. In December 1977, she was informed that her disability had ceased. This determination was reversed on March 31, 1978 by an administrative law judge (Judge Ohanian) after a hearing, and plaintiff's benefits continued. In June 1979, she was informed that her disability had ceased in April 1979. After a hearing on August 20, 1979, another ALJ (Judge Varni) upheld this decision. When the Appeals Council declined to review the decision of the ALJ, it became the final decision of the Secretary. In due course, adopting the conclusions and findings of a federal magistrate, the district court affirmed, and this appeal followed.

Claimant argues that the decision was not based on substantial evidence, that various of her procedural rights were abused, and that the determination resulted from illegal use of social security regulations as a substitute for an individualized inquiry into her disability.

Claimant's attack on the use of 20 C.F.R. §§ 416.902 *et seq.* as the basis for a disability determination is not well taken. However, because the decision of the Secretary is not supported by substantial evidence, we reverse.

I. BACKGROUND

Claimant underwent a lumbar laminectomy in 1973. On the basis of a report from Dr. Tsuneo Hirabayashi relating to a November 28, 1977 consultative examination, the Social Security Administration determined that claimant's disability had ceased in November of 1977. In his decision overturning this determination, Administrative Law Judge Ohanian observed:

> Dr. Hirabayashi gave diagnostic impression of status post operative lumbar laminectomy L5-S1, and concluded that the claimant could do light work. It does not appear that this opinion fully considered the claimant's mental-emotional state and her subjective complaints of severe pain.

He went on to say:

> Crucial to the determination of disability is resolution of the question of the degree of severity and duration of the pain suffered by the claimant together with findings on the extent of restrictions and limitations imposed on the claimant's ability to perform work activities and the existence of residual functional capacity to perform a job. These questions must of necessity be largely resolved, by the credibility that may properly be attributed to the claimant's allegations of subjective symptoms and resulting functional loss.

Judge Ohanian's resolution of these questions was expressed in his findings that:

> 3. On October 2, 1973, the claimant underwent lumbar laminectomy at L4-L5 and L5-S1; possible residuals of such surgery could cause severe disabling pain.

4. At the hearing of March 23, 1978, the claimant gave credible testimony of constant moderate to severe pain in her back and left leg.
5. The claimant's subjective complaints when considered in light of the medical evidence, warrants [sic] a finding of continuing disability.
6. A preponderance of the substantial credible evidence establishes a medically determinable impairment which has caused a level of pain that has prevented the claimant from working on a sustained basis beginning February 19, 1976 and continuing through the date of this decision.

However, Judge Ohanian also noted that 20 C.F.R. § 404.1507 provides that a claimant who "willfully fails to follow prescribed treatment cannot by virtue of such failure be found to be under a disability," and observed that "the claimant . . . should not expect the Administration to continue payment of benefits, if she willfully fails to follow prescribed treatment to alleviate her impairment." In this connection, Judge Ohanian found that her impairment "could reasonably be regarded as partially remediable and possibly substantially remediable," and that "[c]onsequently, she should take reasonable action to treat and alleviate her symptoms and impairments." He also found that her impairments should be reevaluated "at some appropriate future date."

Thereafter, claimant began undergoing treatment in the office of Dr. Morrie Brandman,[1] a specialist in family practice, and subsequently from Dr. William P. Bracciodieta, a neurologist. She also availed herself of the vocational services of the California Department of Rehabilitation.

In June 1979, the Administration informed claimant that her disability was considered to have ended in April 1979, and that her benefits would cease at the end of June 1979. In August, Administrative Law Judge Varni upheld this determination. His decision was based on medical reports from Dr. Brandman and Dr. Bracciodieta, and on the results of electromyographic and radiological studies undertaken at Dr. Bracciodieta's request. It was further based on his assessment of the claimant's testimony at the hearing as to subjective symptoms of pain, and his assessment of the testimony of Mr. Rene Garcia, a program supervisor with the California Department of Rehabilitation, who testified on claimant's behalf.

II. THE MEDICAL REPORTS

The central issue in this appeal is whether the various medical reports furnish an adequate basis for the findings and decision of the tribunals below that claimant's disability has ceased. We turn first, therefore, to an examination of those reports.

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[1] Although Dr. Barndman's name and signature appear on the Medical Report Form filed on May 23, 1979 with the Administration, the substantive portions of the form simply refer to the attached medical records. Those records bear the signature of, and seem to have been compiled by, a Dr. R. Fleming Jones, apparently a physician working in Dr. Brandman's office. Nevertheless, the parties to this action, the ALJ, the magistrate, and the district judge, all refer to Dr. Brandman as the treating physician and the author of the reports.

a. *The Brandman Reports*

Judge Varni's review of the Brandman reports was as follows:

> The relevant medical evidence consists in part of records from Dr. Morrie Brandmann [sic] a specialist in family practice who has been following the claimant since August 14, 1978. The records indicate that the claimant has been mildly hypertensive and was treated by Dr. Brandmann for that problem and that she was considerably obese. Dr. Brandmann's office notes under date of September 15, 1978 indicate the claimant's blood pressure at 140/98 and her weight at 181-3/4 pounds. The note also contains the information that the claimant was "feeling not too bad". Under date of October 4, 1978 the claimant's blood pressure was noted to be 128/84 and her weight 179 pounds. The notation was also made that the claimant "feels fine". It was also noted that she was "doing well". On November 7, 1978 claimant's blood pressure was found to be 140/90 and her weight 181 pounds. Again it was noted that the claimant "feels fine". Under date of February 15, 1979 which is the last entry in evidence claimant's weight was 177 pounds and her blood pressure 140/100.

Study of his entire decision suggests quite clearly that Judge Varni relied in part on the notations in the Brandman reports to the effect that the claimant "feels fine" or is "feeling not too bad" to discount her own testimony that she was, and had been, in almost constant, severe pain. The other information he abstracts from the Brandman reports does not seem to have any direct bearing on whether she was still suffering from her earlier lumbar problems, nor whether she was willfully failing to seek effective treatment for them. In light of this reliance, examination of the Brandman reports themselves is revealing. First of all, the entries relating to blood pressure, weight, and pulse are clearly in a different handwriting from the remainder of the notations. They all come at the beginning of the notations for each day's visit. All of the damning comments ("feels fine," etc.) occur in these initial notations. These facts suggest (although they do not prove) that these notes were written not by Dr. Brandman or Dr. Jones,[2] but by a nurse or other office assistant. That possibility raises obvious questions as to the weight these comments ought to be given in assessing the claimant's disability. Those questions are nowhere discussed, or even mentioned, by the ALJ, the magistrate, or the district judge. We decline to speculate whether we would be obliged to uphold an explicit finding that these remarks represented the clinical impressions of a treating physician. In the absence of such a finding, however, we are not persuaded that the remarks furnish any significant evidence of the claimant's medical condition. Secondly, although Judge Varni relates only that Dr. Brandman treated claimant for hypertension, the notes clearly indicate a diagnosis of "Post Lumbar Disc Pathology."[3] These records simply do not contain any evidence that we can detect that the claimant's condition had improved at all.

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[2] See footnote 1, *supra*.

b. *The First Bracciodieta Report*

This report, dated 4/24/79, is described by Judge Varni as follows:

> There is also in evidence a report dated April 24, 1979 from Dr. William P. Bracciodieta a neurologist who has been following the claimant since that date. On neurologic examination Dr. Bracciodieta noted that the mental status was essentially unremarkable. The cranial nerves serially tested were within normal limits. The motor system showed normal power, tone, and coordination in both the upper and lower extremities. The deep tendon reflexes were elicited. Sensory examination revealed only patchy dysesthesias in the L4-5 and L5-S1 dermatones bilaterally. Examination of the spine revealed no evidence of paravertebral muscular spasm.

Left out is Dr. Bracciodieta's "diagnostic impression": "Chronic low back pain syndrome with probable chronic, non-progressive radiculopathy." Also unmentioned is the fact that this report indicates no change, as far as we can tell, from the neurological study performed by Dr. Hirabayashi in November 1977, in which, aside from slightly diminished sensations in the medial half of the left foot, and a slight weakness in motor power on the right side, the results were all normal. That report, of course, was already determined by Judge Ohanian in the 1978 hearing to be consistent with the continuing existence of claimant's disability.

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[3] The notes for 8/14/78 include the following:

Diag: (1) Hypertension
(2) Post-Lumbar Disc Pathology

Those for 8/22/78 include:

Diag: (1) Hypertension
(2) Post-Lumbar Disc Syndrome
(3) Chronic Tension

Those for 9/8/78 include:

Diag: (1) Hypertension
(2) Lumbar Disc Syndrome
(3) Chronic Tension [illegible]

c. *The Electromyographic and X-Ray Studies*

Judge Varni also relied on the EMG and X-ray studies ordered by Dr. Bracciodieta.[4] Judge Varni correctly relates that the myograms were not "positive for the existence of any neuropathology." Left out, however, is this statement of the physician who performed the tests:

> It should be emphasized, however, that because of the patient's previous back surgery, examination of the paraspinal muscles may be unreliable. She has probably severed her dorsal rami during the course of surgery and therefore, she could conceivably have a herniated disc, in spite of the fact that we did not pick up a positive examination on her paraspinals. This EMG should be correlated with the patient's clinical condition.

Judge Varni also correctly reports that the X-rays disclosed only "mild degenerative and post-surgical changes." Again, however, this represents no change from the clinical status of the claimant at the time of the prior hearing.

The account above comprehends all of the medical evidence relied on below to support the Secretary's determination that the claimant's disability has ceased. We are of the opinion that it does not comprise substantial evidence of any change in the claimant's condition since the 1978 hearing and determination of disability. Under the controlling principles of law, as we explain below, that fact is dispositive.

III. APPLICABLE LEGAL STANDARDS

When the Administration has determined that a claimant's disability has ceased, the burden of proof to establish otherwise lies with the claimant. *Gonzalez v. Harris*, 631 F.2d 143, 145 (9th Cir. 1980). Furthermore, the burden "is a continuing one. It does not cease or shift after an initial ruling of disability has been had." *Id.* In an appropriate case, however, a prior ruling of disability can give rise to a presumption that the disability still exists. "Once evidence has been presented which supports a finding that a given condition exists, it is presumed in the absence of proof to the contrary that the condition has remained unchanged." *Rivas v. Weinberger*, 475 F.2d 255, 258 (5th Cir. 1973). A presumption, of course, does not affect the ultimate burden of proof. It does, however, impose "on the party against whom it is directed the burden of going forward with evidence to rebut or meet the presumption."

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[4] Judge Varni's observations were as follows:

> At the request of Dr. Bracciodieta electromyographic studies of the lower extremities and associated paravertebral musculature were performed together with a nerve conduction [sic] studies of both lower extremities. The nerve conduction studies of both lower extremities were within normal limits and not demonstrative of any neuropathology. The electromyogram was also interpreted as being a normal study so far as could be determined considering the claimant's prior lumbar laminectomy. in any event neither electrodiagnostic study was positive for the existence of any neuropathology. X-rays of the lumbosacral spine taken on April 25, 1979 were interpreted by a radiologist as showing evidence of a partial laminectomy on the right at the L5 level. There was said to be a very slight disc space narrowing at the L4-5 level otherwise the stature, alignment, and disc spaces were unremarkable. No significant degenerative hypertrophic changes were apparently found by the radiologist. Flexion and extension views demonstrated appropriate motion at all levels within normal limits. The impression was mild degenerative and post-surgical changes as previously noted.

Fed. R. Evid. 301.

The Secretary's own regulations provide that the decision of an ALJ on a disability question becomes binding "on all parties to the hearing" if none of the specified avenues of review are exercised by the claimant or the Secretary. 20 C.F.R. § 416.1455 (1981). In the present case, neither the Secretary nor the claimant saw fit to disturb the 1978 determination by an ALJ that the claimant was disabled at that time. The question before us now, therefore, is whether that determination gave rise to a presumption at the time of the 1979 hearing that the claimant was still disabled—a presumption which the Secretary was required to "meet or rebut" with evidence that her condition had improved in the interim. We answer that question in the affirmative. We are unable to discern any reason why the familiar principle that a condition, once proved to exist, is presumed to continue to exist, should not be applied when disability benefits are at stake. The Fifth Circuit has expressly approved such application. *Rivas v. Weinberger, supra. Accord, Prevette v. Richardson*, 316 F. Supp. 144, 146 (D.S.C. 1970). In *Prevette*, the district court reversed the Secretary's determination denying disability benefits where there had been a prior determination of disability, and where neither of the two subsequent medical reports indicated recovery by the claimant. The case before us is almost identical.

As we have said, when a claimant is entitled to the benefit of a presumption that her disability still exists, the burden is still on her to prove her case. All the presumption does is impose on the Secretary a burden to come forward with evidence that her condition has changed. Whether that burden has been met is a judgment to be made initially by the Secretary, and that judgment cannot be overturned on appeal if it meets the "substantial evidence" standard. *See, e.g., Gonzalez v. Harris, supra*, 631 F.2d at 145. But where, as here, there is essentially no evidence to support a conclusion that the claimant's condition has changed, the substantial evidence standard has not been met. Accordingly, we REVERSE.

Part IB
Rulings Based on Program Policy Statements

(Previously Published as PPS-73) **SSR 82-50**

TITLE II: DEFINITION OF LIVING IN THE SAME HOUSEHOLD

PURPOSE: To revise the definition of "living in the same household."

CITATIONS (AUTHORITY): Sections 202(i) and 216(h)(1)(B) of the Social Security Act; Regulations No. 4, sections 404.346, 404.347, 404.390, and 404.760; Commissioner's Decision dated February 19, 1982.

PERTINENT HISTORY: To qualify for the lump-sum death payment (LSDP) as a spouse living in the same household, the widow(er) and the deceased must have been "customarily living together as husband and wife in the same residence," according to section 404.347 of the Social Security Regulations. Temporary separations do not necessarily preclude the Social Security Administration (SSA) from considering a couple to be living in the same household. However, SSA generally has considered extended separations (including most that last 6 months or more) to be indicative that the couple was not living in the same household. Therefore, in situations where medical reasons alone forced a husband and wife to live apart, SSA had considered the couple not to be living in the same household.

Prior to the passage of Public Law (P.L.) 97-35, the widow(er) of the worker could qualify for the LSDP if he or she had been living in the same household as the deceased when the latter died or, under certain conditions, if he or she paid the burial expenses of the deceased worker. This provision ensured that a widow(er) who was not living in the same household as the deceased could still receive the LSDP if he or she performed in a manner which demonstrated strong concern for the worker. In the majority of cases where spouses lived apart solely due to medical reasons, the widow(er) qualified for the LSDP by paying the burial expenses without the necessity of establishing eligibility under the "living in the same household" test. P.L. 97-35 redefined who may qualify for the LSDP. Under the new law, a spouse can qualify for the LSDP only if (1) he or she was living in the same household as the deceased worker at the time of death, or (2) he or she was entitled to (or eligible for) benefits on the worker's record for the month in which the worker died. Payment of the worker's burial expenses no longer has any bearing on who may qualify for the LSDP.

With the changes made by P.L. 97-35, certain spouses separated solely due to medical reasons must satisfy the "living in the same household" definition to qualify for the LSDP. An example follows:

> A worker had been living in a nursing home for 3 years prior to his death because his wife was unable to provide the daily medical care he needed. Until his death, the worker was visited frequently by his wife, who lived in the house to which the worker would have returned if he were able. Because the widow was receiving a retirement benefit which exceeded her late husband's primary insurance amount, she was not eligible for benefits on her late husband's record. Based on current law and the current definition of "living in the same household," this widow would not qualify for the LSDP.

SSA believes that the living in the same household definition contained in section 404.347 of the regulations is broad enough to include widow(er)s situated like the one above. Accordingly, the Commissioner has expanded the operational definition of "living in the same household" to include extended separations due to the confinement of either spouse in a nursing home, hospital, or other curative institution; that is, as long as evidence indicates the husband and wife were initially separated, and continued to be separated, *solely* for medical reasons and would otherwise have resided together, they would be considered to be "living in the same household."

This revised definition arose in regard to the LSDP provision, but will also apply to deemed marital relationships under section 404.346. A spouse filing for benefits based on a deemed marriage must be living in the same household with the worker at the time the application is filed (if the worker is living) or at the time of the worker's death. The revised definition of "living in the same household" described in this policy statement applies in both life and death cases in which a deemed marital relationship is involved.

POLICY STATEMENT: If a husband and wife are (or were) separated and continue(d) to be separated, *solely* for medical reasons, SSA may consider them to be living in the same household even if the separation is (or was) likely to be permanent and there is (or was) little or no expectation of the parties again physically residing together. As long as the spouse who is now applying for the LSDP or spouse's benefits based on a deemed marriage has continued to demonstrate strong personal and/or financial concern for the worker, SSA will assume they would have lived together (absent evidence to the contrary) had the medical reasons not necessitated their separation, and will pay the LSDP or spouse's benefits to the spouse.

To establish that a spouse satisfies the above requirement, he or she will be asked to sign a statement (and in some cases to submit other evidence) that confirms the reason for the initial and continued separation from his or her spouse.

EFFECTIVE DATE: This revised definition is effective for all LSDP claims and deemed spouses' claims finally adjudicated on or after March 4, 1982 (the date the processing instructions implementing the Commissioner's decision were issued to field offices) *except* those claims where the LSDP has already been correctly paid to another person under previous instructions. Also, the definition applies to any disallowed LSDP claims that SSA identifies if the claim is based on a death after August 1981 (when P.L. 97-35 became effective) and the LSDP has not already been paid.

CROSS-REFERENCES: Claims Manual sections 706-712, A702; Program Operations Manual System section GN 00210.025-00210.045; GN 00305.170-00305.205.

TITLES II AND XVI: GUIDELINES FOR RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT IN MUSCULOSKELETAL AND CARDIOVASCULAR IMPAIRMENTS

PURPOSE: To identify levels of work (in terms of physical exertion requirements) precluded by physical limitations resulting from certain musculoskeletal and cardiovascular impairments and to give focus to additional functional restrictions which may be associated with these impairments and which should be considered in assessing an individual's residual functional capacity (RFC). (The responsibility for assesing RFC is discussed in SSR 82-30 (PPS-64: Responsibility for Residual Functional Capacity Assessments).)

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act, as amended; and Regulations No. 4, Subpart P, section 404.1545; and Regulations No. 16, Subpart I, section 416.945.

PERTINENT HISTORY: Residual functional capacity represents the measure of an individual's remaining ability to perform particular work-related physical and mental functions despite the limitations imposed by the individual's severe impairment(s) which does not meet or equal an impairment listed in Appendix 1, Subpart P, Regulations No. 4.

In determining whether an individual is disabled (except for a widow(er) or surviving divorced spouse under title II and a child under title XVI of the Act), we follow a sequential evaluation process, whereby current work activity, severity and duration of the impairment(s), ability to do past work, and vocational factors are assessed, in that order. If the claimant is not currently engaging in substantial gainful activity and medical considerations alone are not determinative, RFC must be considered to determine if the claimant can still do his or her previous work. If the claimant cannot, RFC is then considered in combination with the vocational factors of age, education and work experience to determine if he or she can do any other jobs which exist in significant numbers in the national economy.

In recognition of the need for additional guidance in documenting and assessing RFC, examples of impairments which, when present, result in predictable limitations of physical function have been identified. These represent ten commonly occurring impairments in the musculoskeletal body system and six commonly occurring cardiovascular impairments. These two body systems were selected because they are involved in the majority of disability claims.

POLICY STATEMENT: Based on case experience and consultation with disability program physicians throughout the nation, the following impairments have been identified as resulting in predictable physical limitations which preclude specific levels of work based on physical exertion requirements. The reference in the examples to sedentary, light, medium, and heavy work correspond to the description of these work levels in Regulations No. 4, Subpart P, section 404.1567, and Regulations No. 16, Subpart I, section 416.967.

In many examples, it has not been possible to state a general conclusion on RFC. In such examples, the level of work that is precluded is stated first (e.g., heavy work), followed by the additional restrictions, which, when present, further restrict the RFC. The extent to which any example can be directly applied to adjudication will depend on vocational considerations. For example, the first musculoskeletal item (A.1.) states that an individual who meets the description provided for rheumatoid arthritis is unable to perform heavy work. If an individual meets the description in this example and the subsequent vocational assessment establishes that this individual has the vocational capability to perform only jobs requiring heavy work, a favorable decision is warranted. If the vocational assessment shows a vocational capability to perform work below the heavy level, the additional functional considerations in the example are used to distinguish between the functional capacity to perform medium, light and sedentary work.

The conclusions in these examples are directly applicable to the decision only when the individual has no limitations other than those resulting from the medical condition specifically described in each example. The examples are primarily related to physical capacities, including the capacity for sustained exertion, and additional reduction of RFC in other areas—mental, for example—will require further consideration.

A. Examples of Musculoskeletal Impairments

1. Rheumatoid arthritis with clinical evidence of continued activity corroborated by laboratory tests without significant restriction of function of the affected joints. Heavy work activity would be precluded. The distinction between the capacity to perform medium, light and sedentary work activity requires consideration of the joints involved, the extent of involvement, any residual abnormality of these joints, and the status of associated muscles. Consideration of limitation of walking or standing may be pertinent if major joints of the lower extremities are involved. Fine and gross manipulation may be limited if there is involvement of the fingers, hands, or wrists. The complications from, or the side effects of, large doses of medication must be considered.
2. Osteoarthritis of major joints of the lower extremities (hip, knee, ankle) with pain and abnormal finding on physical examination demonstrating significant interference with function of one or more joints and abnormal findings on X-ray. Heavy work activity would be precluded. The distinction between the capacity to perform medium, light and sedentary work activity requires consideration of the joints involved, the extent of involvement (particularly of limitation of motion), and evidence of atrophy of muscles

moving that joint. There must be consideration of whether the impairment imposes a significant limitation on walking or standing or more specific activities such as repeated operation of foot controls or climbing stairs.

3. Osteoarthritis of major joints of the upper extremities (shoulder, elbow, wrist-hand) with pain and abnormal findings on physical examination demonstrating significant interference with function of one or more joints and abnormal findings on X-ray. Heavy work activity would be precluded. The distinction between the capacity to perform medium and light work activity requires consideration of the joints involved. Consideration must be given as to whether involvement of the shoulder or elbow significantly restricts the individual's reach.

4. Amputation of lower extremity above the knee, with ability to use prosthesis effectively. The impairment is considered to impose a significant limitation on walking, standing, and climbing stairs. The individual would be limited to sedentary work activity. (Note: These criteria do not apply to amputations due to peripheral arterial disease or diabetic necrosis. See Listing 4.13C or 9.08C.)

5. Amputation of lower extremity at or above the tarsal region, but below the knee, with ability to use prosthesis effectively. Heavy work activity would be precluded. Usually there is not significant restriction in the ability to walk or stand unless there is a complication of the amputation site. There would be a limitation on excessive climbing of stairs and walking on grossly uneven terrain and operating foot controls with the affected extremity. (Note: These criteria do not apply to amputations due to peripheral arterial disease or diabetic necrosis. See Listing 4.13C or 9.08C.)

6. Amputation of upper extremity above the elbow. The individual would be limited to light work activity with additional limitations because of loss of bimanual manipulation and difficulty or inability to handle bulky objects. The limitation on fine manipulation even with the remaining hand would depend upon which was the dominant extremity, the time since loss of the extremity, and subsequent acquisition of any fine manipulative abilities by the remaining nondominant extremity.

7. Amputation of upper extremity below the elbow. Heavy work activity would be precluded. The distinction between the capacity to perform medium and light work activity requires consideration of the extent and condition of the remaining stump and the ability to use a prosthesis. There would be a loss of bilateral fine manipulation and

some limitation of gross manipulation. The limitation on fine manipulation, even with the remaining hand, would depend upon which was the dominant extremity, the extent and condition of the remaining stump, the time since loss of the extremity, and subsequent acquisition of any fine manipulative abilities by the remaining, nondominant extremity.

8. Replacement of hip or knee. Heavy and medium work activity would be precluded, but the individual is not automatically restricted to sedentary work activity. Function returning after full recovery from surgery must be evaluated to determine the capacity for light work activity. In the evaluation, limitation of walking is a more important consideration than limitation of standing. Consideration must be given to range of motion of the joint, integrity of the associated musculature, evidence of loosening of the prosthesis, and evidence of significant arthritis in other major joints.

9. Status postsurgery for excision of lumbar disc with significant abnormal physical findings short of meeting the Listing. Heavy work activity would be precluded and bending and stooping would be limited. The distinction between the capacity to perform medium, light and sedentary work activity requires consideration of the severity of the underlying orthopedic impairment and any residual neurological abnormalities. Further limitations on ability to walk, stand, or operate foot controls would have to be considered if warranted by the severity of the impairment.

10. Stable fusion of lumbar vertebrae without neurological complications. Heavy work activity would be precluded, but ability to engage in medium work activity ordinarily would be retained. Bending and stooping would be limited. Significant limitation in walking and standing is not expected.

B. Examples of Cardiovascular Impairments

1. Ischemic heart disease with angina, treadmill exercise test "negative" at 5 METs, but "positive" at 7 METs or less. Medium work activity would be precluded, but ability to engage in light work activity ordinarily would be retained unless restricted by other cardiac impairments such as congestive heart failure. (The terms "negative" and "positive" are defined in Listing 4.04A.)

2. Ischemic heart disease with angina, treadmill exercise test "negative" at 7 METs, but "positive" at 10 METs or less. Heavy work activity would be precluded, but ability to engage in medium work activity ordinarily would be retained

unless restricted by other cardiac impairments such as congestive heart failure. (The terms "negative" and "positive" are defined in Listing 4.04A.)

3. Postmyocardial infarction or coronary artery bypass graft, without angina, congestive heart failure, or significant arrhythmias. Heavy work activity would be precluded unless specific exercise testing establishes the ability to engage in heavy work activity. The distinction between the capacity to perform medium and light work activity requires consideration of the medical evidence describing the individual's clinical condition.

4. Previous congestive heart failure because of "chronic" heart disease, currently compensated and with electrocardiographic and X-ray abnormalities not currently meeting requirements of Listing 4.02. Heavy work activity would be precluded. The distinction between the capacity to perform medium and light work activity requires consideration of the underlying heart disease and the residual impairment.

5. Hypertension without previous congestive heart failure, but with electrocardiographic evidence of left ventricular strain pattern as shown in Listing 4.02.B.2. Heavy work activity would be precluded. The distinction between the capacity to perform medium and light work activity requires consideration of the medical evidence describing the individual's clinical condition, including the extent of cardiac abnormality and any adverse effects of medication.

6. Replacement of heart valve. Heavy work activity would be precluded. The distinction between the capacity to perform medium and light work activity requires consideration of the underlying heart disease, the type of surgery performed, and the residual impairment.

FURTHER INFORMATION: There is a continuing effort to provide similar examples of RFC for other body systems.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCE: Program Operations Manual System DI 2210.

TITLES II AND XVI: DURATION OF THE IMPAIRMENT

PURPOSE: To state and explain the policy regarding the duration requirement under the disability provisions of titles II and XVI of the Social Security Act and implementing regulations.

CITATIONS (AUTHORITY): Sections 223(d), 216(i), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1505, 404.1509, 404.1522, 404.1598; and Regulations No. 16, Subpart I, sections 416.905, 416.909, 416.922, and 416.998.

INTRODUCTION: To be found disabled, and individual must be unable to engage in any substantial gainful activity (SGA) by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of at least 12 months. In considering "duration," it is the inability to engage in SGA because of the impairment that must last the required 12-month period. (See Social Security Ruling (SSR) 73-7c.) This policy statement explains in detail the documentation and evaluation requirements for determining if the duration requirement is met.

POLICY STATEMENT: "Duration of impairment" under title II and title XVI refers to that period of time during which an individual is continuously unable to engage in any SGA, or any gainful activity in the case of a title II widow, widower, or surviving divorced spouse or a title XVI child under age 18, because of a medically determinable physical or mental impairment(s). (There is no duration requirement for title XVI statutorily blind individuals, but the duration requirement does apply to title II statutorily blind individuals.) It extends from the date of onset of "disability" to the time the impairment(s) does not prevent the individual from engaging in SGA (or any gainful activity as appropriate), as demonstrated by medical evidence or the actual performance of SGA. An individual who was previously entitled to a period of disability must again meet the duration requirement before a subsequent period of disability can be established, even though a second waiting period under title II may not be required in certain instances.

The 12-Month Duration Requirement

Since the Social Security Amendments of 1965, the disabling impairment(s) preventing an individual from engaging in SGA (or any gainful activity) must be expected to result in death, or must have lasted (or be expected to last) for at least 12 continuous months from the date of onset (e.g., from January 17, 1981, through January 16, 1982). Exception: The duration and SGA requirements are not applicable in determining blindness under title XVI. (See SSR 82-53 (PPS-74: Basic Disability Evaluation Guides).)

Severe impairments lasting less than 12 months cannot be combined with successive, unrelated impairments to meet the duration requirement. For example, if an individual had two unrelated incapacitating impairments, one lasting for only 9 months and the other developing 6 months after onset of the first and lasting for only 7 months, the duration requirement is *not* met since neither impairment lasted at least 12 months even though the individual's inability to work lasted for a total of more than 12 months. Where only the second impairment is of requisite severity and duration, onset of disability would be the first day that the *second* impairment became disabling. Onset cannot be extended back to the date of the first impairment if that impairment itself was disabling for less than 12 months.

In determining whether a beneficiary's disability continues, if a new disabling impairment(s) begins in or before the month in which the last disabling impairment(s) is no longer disabling, disability is found to be continuing. Inasmuch as the individual has already met the "duration" requirement, the new impairment need not be expected to last 12 months or to result in death, but it must be so severe as to preclude SGA (or any gainful activity as appropriate).

Return to Work Within 12 Months of Onset

Entitlement to benefits can be established to begin after the 5-month waiting period in title II claims (or with the first full month of disability in a no-waiting period case, i.e., a previous period of disability ceased within 5 years before the month the current disability began), or as of the month of application or onset, whichever is later, in title XVI claims, when the "disabling" impairment(s) is expected to result in death or has lasted or can be expected to last for at least the required 12-month period. When an individual whose entitlement is established on the basis of expected duration returns to work which demonstrates ability to engage in SGA after an award of benefits but within the 12-month period after onset, benefits should be terminated (subject to the possible entitlement of the individual to a trial work period). The prior award should not be reopened and reversed.

When the return to work demonstrating ability to engage in SGA occurs before approval of the award and prior to the lapse of the 12-month period after onset, the claim must be denied. When an individual returns to SGA during the waiting period and such work continues, the claim for benefits must be denied if the award has not been approved. If the award was previously approved, the claim must be reopened and revised to a denial. If the work attempt proves unsuccessful or detrimental to health, the determination of denial may later be reopened and revised to an allowance. However, the determination or decision can only be reopened within the time limitations under the rules of administrative finality (see Regulations No. 4, sections 404.987 and 404.988; and Regulations No. 16, sections 416.1487 and 416.1488).

Projecting Severity and Residual Functional Capacity

In most cases in which the evidence substantiates a finding of disability, it will be readily apparent from the same evidence whether or not the impairment is expected to result in death or has lasted or is expected to last 12 months from the onset of disability. When the application is being adjudicated (or a hearing decision is being issued) before the impairment has lasted 12 months, the nature of the impairment, the therapeutic history, and the prescribed treatment will serve as the basis for determining whether the impairment is expected to result in death or will continue to prevent the individual from engaging in any SGA (or any gainful activity) for the additional number of months needed to make up the required 12 months duration (e.g., 7 months for the claim being adjudicated in the 5th month, etc.). In the case of a title II worker or childhood disability benefits (CDB) applicant, or a title XVI claimant age 18 or older, a projection of how severe the impairment will be 12 months after onset may also require an estimate of the claimant's residual functional capacity (RFC) as of the 12th month after onset (i.e., the impairment falls short of the level of severity depicted by the Listing, yet there are significant limitations to performing basic work-related functions).

Documentation

In order to determine the duration of the impairment, the medical reports should reflect all the pertinent symptoms, signs, and laboratory findings, as well as prescribed treatment (drug dosage and frequency of administration, surgery, radiation, etc.), and the response to treatment in terms of changes in symptoms, signs, and laboratory findings. (For a more complete discussion on the contents of medical reports, see SSR 82-14 (PPS-63: Requirements for Consultative Examinations and Tests Purchased in Claims Based on Disability).) When the patient is unwilling to accept the treatment or he or she is unable to carry it out, the specific details should also be reported. (See SSR 82-59 (PPS-78: Failure to Follow Prescribed Treatment).)

Evaluation

When the evidence shows that at 12 months after onset the individual's impairment(s) did not or will no longer meet or equal the Listing (in the case of a title II widow, widower, or surviving divorced spouse, or a title XVI child under age 18), or that the individual is or will be able to return to SGA within 12 months after onset (in the case of a title II worker or CDB applicant, or a title XVI claimant age 18 or older), a finding that the individual is not disabled should be made on the basis that the duration requirement is not or will not be met. Adjudication on the basis of "insufficient duration," therefore, indicates that a claim which would have been allowed must instead be denied because the claimant's impairment was not or will not be disabling for at least 12 months.

The denial determination or decision for insufficient duration should not be understood as independent of the sequential evaluation process. (See SSR 82-56 (PPS-81): The Sequential Evaluation Process).) Rather, it is necessary to follow the principles of sequential evaluation in assessing an alleged impairment according to the duration requirements of the law.

Denial for insufficient duration is applicable in all cases in which:

1. The impairment(s) was or is of such severity that the claimant was or is unable to engage in any SGA (or any gainful activity); but
2. By the end of 12 months, the impairment is, or will be, no longer of such severity as to prevent SGA.

All cases denied on the basis of insufficient duration must state clearly in the denial rationale that either:

1. Within 12 months of onset, there was or is expected to be sufficient restoration of function so that there is or will be no significant limitation of the ability to perform basic work-related functions. (See SSR 82-55 (PPS-84: Medical Impairments That Are Not Severe)); or
2. Within 12 months of onset, there was or is expected to be sufficient restoration of function so that in spite of significant remaining limitations the individual should be able to do past relevant work or otherwise engage in SGA, considering pertinent vocational factors.

In the latter case, a thorough documentation, evaluation, and rationalization of the claimant's RFC, work history, and vocational potential will be necessary. (See SSR 82-56 (PPS-81: The Sequential Evaluation Process).)

A denial determination or decision on the basis of insufficient duration may be made either within the 12-month period after onset or at any time following the 12-month period after onset, since the basis for such a determination is not the date of adjudicative action, but the level of impairment severity within a 12-month period.

A claim from a title II worker or CDB applicant, or from a title XVI individual age 18 or older, should be denied on the basis of ability to engage in past or other work (as opposed to the basis of insufficient duration) if the evidence shows that the claimant's impairment(s):

1. Is severe or is expected to be severe at 12 months after onset, but is not expected to preclude SGA in relevant past work or other work; *and*
2. During the period under adjudication has never been of such severity as to preclude the claimant's engaging in SGA for a continuous period of 12 months. (See SSR 82-56 (PPS-81: The Sequential Evaluation Process).)

When a claimant has established that an impairment precludes any SGA and is expected to last 12 months from onset, the possibility that ability to engage in SGA may be restored despite the impairment(s) (e.g., through rehabilitation) does not preclude a finding of "disability."

The actual duration of many impairments subject to improvement is directly related to the therapeutic regimen administered by the treating physician. An individual with a disabling impairment which is amenable to treatment that would be expected to restore the ability to work would meet the duration requirement if he or she is undergoing therapy prescribed by treatment sources, but disability, nevertheless, has lasted, or can be expected to last, for at least 12 continuous months.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCES: Program Operations Manual System, sections DI 2096, DI 00504.115, and DI 00504.120.

TITLES II AND XVI: BASIC DISABILITY EVALUATION GUIDES

PURPOSE: To provide an overview and a further explanation of the definition and terms contained in the disability provisions of title II and title XVI of the Social Security Act and implementing regulations. (A separate Program Policy Statement, SSR 82-56 (PPS-81: The Sequential Evaluation Process) provides an overview of that process in disability adjudication.)

CITATIONS (AUTHORITY): Sections 223(d), 216(i), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1505, 404.1508, 404.1509, 404.1513, 404.1525, 404.1526, 404.1528, 404.1545, 404.1566, 404.1577, 404.1578, 404.1581, 404.1582, 404.1583, 404.1584, and Appendix 1; Regulations No. 16, Subpart I, sections 416.905, 416.906, 416.908, 416.909, 416.913, 416.923, 416.925, 416.926, 416.928, 416.945, 416.966, 416.981, 416.983, 416.984, and 416.985.

INTRODUCTION: Several terms included in the various definitions of disability and blindness (under titles II and XVI) and other terms closely related to the concept of disability are subject to more than one possible interpretation. This policy statement explains the various definitions of disability and blindness and describes in detail how pertinent terms are to be interpreted and applied.

POLICY STATEMENT:

Definitions of "Disability"

Under title II, the term "disability" means—

1. In the case of a worker or applicant for childhood disability benefits (CDB), inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

2. In the case of a widow, widower, or a surviving divorced spouse (DWB) applicant, the existence of a medically determinable physical or mental impairment(s) expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, and of a level of severity which under the regulations prescribed by the Secretary, is deemed to be sufficient to preclude an individual from engaging in any gainful activity.

   The individual must have a physical or mental impairment(s) which meets or equals the level of severity described in the Listing of Impairments. Disability for a DWB applicant will be decided on medical considerations alone (i.e., vocational considerations do not apply); or

3. In the case of a worker or applicant for CDB who has attained the age of 55 and is blind (see definition of blindness below), inability by reason of such blindness to engage in SGA requiring skills or abilities comparable to those of any gainful activity in which the individual has previously engaged with some regularity and over a substantial period of time.

Under title XVI, the term "disability" means—

1. In the case of a claimant age 18 or over, inability to engage in any SGA by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (See below concerning blindness under title XVI.)

   There are provisions for individuals who are "disabled" according to the definition of "disability" established in a State plan. However, these provisions are not applicable to newly eligible individuals; or

2. In the case of a child under the age of 18, a medically determinable physical or mental impairment(s) which meets the duration requirement described above and is of comparable severity to that which qualifies an individual age 18 or over. Disability is deemed to exist (i.e., to be of comparable severity) if the child is not engaging in SGA, and if the impairment(s) is described in the Listing of Impairments (Part A or Part B); or, if the impairment(s) is not listed but either singly or in combination, with appropriate consideration of the particular effect of disease processes in childhood, is determined to be of comparable severity to that of a listed impairment. The concept of "comparable severity" of children's impairments is applicable (i.e., the child's impairment(s) *must* meet or equal a listed impairment) when the disability claimant is under the age of 18 and is neither married nor the head of a household.

Definition of Blindness

Under title II and title XVI—

"Blindness" is defined in sections 216(i) and 1614(a)(2) of the Social Security Act as central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having a central visual acuity of 20/200 or less.

If the applicable listing is met, statutory blindness is established. However, if a visual impairment does not meet the sta-

> tutory definition of "blindness," consideration must still be given to whether the severity of the impairment is such that the individual may be "disabled" (i.e., the visual impairment prevents the individual from engaging in SGA).

Under title XVI only—

> Unlike claims under title II based upon "blindness," there is no *duration* requirement for "blindness" under title XVI. If a title XVI claimant is found to be otherwise eligible and is blind, he or she is eligible regardless of the anticipated duration of the blindness. (The 12-month duration requirement does not apply once statutory "blindness" is established.)
>
> Statutorily blind individuals are eligible for payments even if they are engaging in SGA, provided the other requirements for eligibility are met; e.g., income and resource specifications.
>
> There are provisions for individuals who are blind according to the definition of "blindness" established in a State plan. However, these provisions do not apply to newly eligible individuals.

Substantial Gainful Activity

"Substantial gainful activity" means the performance of significant physical or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit. "Significant activities" implies not only that the activities are useful in the accomplishment of a job or the operation of a business, but also that they are the kind normally done for pay or profit. Work may be substantial even if it is performed on a part-time basis, or even if the individual does less, is paid less, or has less responsibility than in previous work. Work activity is gainful if it is the kind or work usually done for pay, whether in-cash or in-kind, or for profit, whether or not a profit is realized. Activities involving self-care, household tasks, nonremunerative training, hobbies, therapy, school attendance, clubs, social programs, etc., are not generally considered to be SGA.

Inability to Engage in Any Substantial Gainful Activity: Title II Worker or Applicant for Childhood Disability Benefits/Title XVI Claimant Age 18 or Older

Title II workers or CDB applicants, or title XVI claimants age 18 or older, are unable to engage in any SGA (see SSR 80-35(PPS-42: Substantial Gainful Activity Guidelines For Persons Disabled by Blindness)) if by reason of their impairment(s), they are not only unable to do past relevant work, but cannot, considering their age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy regardless of whether such work exists in the immediate area in which the individuals live, or whether a specific job vacancy exists, or whether the individuals would be hired if they applied for work.

The statute specifies that "work which exists in the national economy" means work which exists in *significant numbers either* in the region where the individuals live *or* in several regions of the country. The purpose of so defining the phrase is not only to make it clear that jobs need not be available in the region in which the individuals live, but also to emphasize that, conversely, a type(s) of job which exists only in very limited numbers or in relatively few geographic locations may not be said to "exist in the national economy." This distinction will assure that individuals are not awarded benefits simply on the basis of lack of jobs in the region in which they live, nor denied benefits on the basis of the presence in the economy of isolated jobs in which the individuals could engage.

Inability to Engage in Any Gainful Activity: Title II Widow, Widower, or Surviving Divorced Spouse/Title XVI Child Under Age 18

In the Listing of Impairments, the regulations describe impairments of a level of severity deemed to preclude an individual from engaging in *any* gainful activity. An applicant for title II disabled widow's, widower's, or surviving divorced spouse's benefits or title XVI child's benefits *must* have an impairment(s) that meets or equals an impairment in the Listing.

As in the case of a title II worker or CDB applicant or a title XVI claimant age 18 or older, a title II widow(er), or title XVI child whose work demonstrates ability to engage in SGA is *not* under a disability. The level of severity of an impairment which a title II widow(er) or a title XVI child must meet or equal to be determined to be under a disability is that which is considered under the regulations to be sufficient to preclude engaging in *any gainful* activity (i.e., must meet or equal the Listing), as distinguished from SGA. The concept of "gainful activity," however, is used only in setting the requisite level of severity of the impairment in the Listing of Impairments and not otherwise.

Types of Claims Determinable Only on the Basis of Medical Factors

Title II: Disabled Widow, Widower, or Surviving Divorced Spouse

The 1967 amendments provided benefits for widows, widowers, or surviving divorced spouses at age 50 or older whose physical or mental impairment(s) is of a level of severity deemed sufficient to preclude an individual from engaging in any gainful activity. Such a level of severity is described in the Listing. In order to qualify for benefits, a widowed person or surviving divorced spouse must, therefore, have an impairment(s) which meets or equals the level of impairment severity in the Listing, and not be engaging in SGA.

Title XVI: Children Under Age 18

Disability in children under age 18 will be determined solely by consideration of medical factors (i.e., vocational factors do not apply). A finding of disability may be made only when the child's impairment or combination of impairments is as severe as the examples contained in the Listing of Impairments (Part A or Part B). When the specified criteria are met or equalled, disability may be established on the basis of the medical facts in the absence of evidence to the contrary (e.g., the actual performance of SGA).

By Reason of . . . Impairment

The physical or mental impairment(s) must be the primary reason for the individual's inability to engage in any SGA (or gainful activity). When, for instance, an individual remains unemployed for a reason(s) not due to a physical or mental impairment(s), such individual may not be considered disabled. Unemployment may be attributable to a number of reasons other than disability: individuals may be unsuccessful in obtaining work they could do; or work they could do may not exist in the local area; or the hiring practices of certain employers, technological changes in the industry, or cyclical economic conditions may preclude their employment; or there may be no job openings; or they would not actually be hired to do work they could otherwise perform.

"Medically Determinable"

The law requires that the physical or mental impairment(s) which results in inability to engage in any SGA (or inability to engage in any gainful activity in the case of a title II DWB applicant or title XVI child) must be a medically determinable impairment(s). This means that the impairment(s) must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

An individual's description of his or her impairment(s) (symptoms) is, in itself, insufficient to establish the presence of a physical or mental impairment(s). For the purposes of determining a "medically determinable impairment," the following definitions apply:

Symptoms are the claimant's own description of the physical or mental impairment(s).

Signs are anatomical, physiological, or psychological abnormalities which can be shown through the use of medically acceptable clinical techniques. Psychiatric signs are medically demonstrable phenomena (apart from the claimant's symptoms), indicating specific abnormalities of behavior, affect, thought, memory, orientation, and contact with reality. They must also be shown by observable facts that can be medically described and evaluated.

Laboratory findings are manifestations of anatomical, physiological, or psychological phenomena demonstrable by the use of medically acceptable laboratory diagnostic techniques. They include chemical, electrophysiological, roentgenological, or psychological tests.

Those aspects of the disability determination that relate to the nature, extent and duration of the impairment must be based on medical facts (i.e., symptoms, signs, and laboratory findings).

Residual Functional Capacity

Residual functional capacity (RFC) is the remaining capacity to perform work-related physical and mental activities despite certain functional limitations resulting from medically determinable impairments. The assessment of RFC must be documented to support the adjudicative conclusion of just what the individual can still do in a work setting, and must be fully responsive to the claimant's statements, including those about symptoms (especially pain) which concern the nature and extent of the impairments.

The RFC assessment is based primarily on the medical findings which must be complete enough to permit and support the necessary judgments concerning the individual's physical, mental, and sensory capacities and any environmental restrictions. Descriptions and observations of the claimant's restrictions by medical and nonmedical sources in addition to those made during formal medical examinations must also be considered in the determination of RFC. When multiple impairments are involved, the RFC is derived from an assessment of the remaining functional capacity after consideration of all impairments. (See SSR 82-56 (PPS-81: The Sequential Evaluation Process).)

Duration of Impairment

Duration of impairment under title II and title XVI refers to that period of time during which an individual is continuously unable to engage in SGA (or any gainful activity) because of a medically determinable physical or mental impairment(s). It extends from the date of onset of "disability" to the time the impairment(s) no longer prevents the individual from engaging in SGA. Since the Social Security Amendments of 1965, the disabling impairment(s) preventing an individual from engaging in any SGA (or any gainful activity) must be expected to result in death, or must have lasted or be expected to last for at least 12 continuous months from the date of onset (e.g., from January 17, 1981, through January 16, 1982). However, there is no "duration" requirement for "blindness" under title XVI. (See SSR 82-52 (PPS-89: Duration of the Impairment for a further explanation).)

Impairment Which Ended Prior to Decision or Determination

Where the evidence establishes that the claimant was unable to engage in any SGA (or gainful activity) for a continuous period of at least 12 months, but by the time the decision or determination is made, the claimant is able to engage in SGA (or gainful activity), he or she may be entitled to disability benefits for all or some of the time he or she was unable to engage in SGA (or gainful activity).

Impairment Which Can Be Expected to Result in Death

An impairment will be considered likely to result in death if, on the basis of established medical knowledge, it is found to be in a terminal state under the particular circumstances in the case. A disabling condition which actually does result in death will be considered one that was "expected to result in death."

One purpose of this concept is to assure that disability may be established for the individual who has an incapacitating impairment which is expected to cause death before it lasts 12 months. However, if in a title II case, death follows so quickly after the alleged onset date of the impairment that a period of disability cannot be granted (i.e., a waiting period applies and the alleged onset is less than 5 full calendar months before the month of death) and an earlier onset cannot be established, the claim will be denied.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCES: Program Operations Manual System, sections DI 2051.B., 2091-2099, 2104, and 2382.1.

(Previously Published as PPS-75) **SSR 82-54**

TITLES II AND XVI: MENTAL DEFICIENCY—INTELLIGENCE TESTING

PURPOSE: To state the policy and describe the standardized intelligence test requirements for evaluating disability in mental retardation cases under titles II and XVI of the Social Security Act.

CITATIONS (AUTHORITY): Sections 223(d), 216(i), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, section 404.1525 and Appendix 1, Part A, sections 12.00B.4 and 12.05, and Part B, sections 112.00B and 112.05; and Regulations No. 16, Subpart I, section 416.925.

INTRODUCTION: Standardized intelligence test results are essential to the adjudication of most cases of alleged mental retardation. This Program Policy Statement (PPS) explains in detail when such tests are needed, the more common types of tests, and how the results should be used in evaluating disability.

POLICY STATEMENT: In the adjudication of cases involving alleged mental retardation, accurate information pertaining to the claimant's daily activities and current behavior is required in order to determine the level of impairment severity. In instances of severe mental retardation, such information may preclude the need for standardized test results altogether. Standardized test results are not required in cases of mental retardation which unequivocally meet or equal either section 12.05A or section 112.05A of the Listing of Impairments. Mental retardation must be manifested by severe mental and social incapacity as evidenced by marked dependence upon others for personal needs (e.g., bathing, washing, dressing, etc.), inability to understand the spoken word, inability to avoid physical danger (e.g., fire, automobiles, etc.), inability to follow simple directions, and inability to read, write, and perform simple calculations. Standardized intelligence test results are essential to the adjudication of all other cases of alleged mental retardation.

If the test results show an IQ of 80 or greater in all major areas of intellectual functioning, the impairment is considered to be not severe. (See SSR 82-55 (PPS–84: Medical Impairments That Are Not Severe).) The specific test administered should be reliable (yield repeatable results), valid (be an accurate measure of what is meant by intellectual ability or intelligence), and be standardized according to accepted psychometric practice and have normative data relating to a recent cross-section of the general population. It is also necessary for the particular test to sample a wide range of the subject's skills and abilities rather than being limited to measuring only one or a few narrow intellectual functions. Tests markedly deficient in one or more of the foregoing qualities should be avoided for purposes of evaluating disability.

Moreover, it should be clearly understood that different tests may not yield identical (or even similar) "IQ" results. The IQ requirements de-noting a disabling impairment under the Listing of Impairments are meant for application in conjunction with tests of general intelligence having IQ means of approximately 100 and standard deviations of approximately 15 in the general population at large (e.g., the Wechsler series (WAIS-R, WISC, WISC-R, and WPPSI) and the Revised Stanford-Binet scales). Thus, IQ's below 60 would reflect a level of intellectual functioning below 99.5 percent of the general population. IQ results of tests with parameters other than the above would obviously require special transformation in order to render them comparable to the requirements stated in the Listing.

It is obviously important to know what test was administered, the date the test was administered, the age of the subject at the time the test was given, whether the results are applicable to the subject's current condition, and the qualifications of the examiner. Adequate resolution of the issues posed by specific cases may require professional consultation with a clinical psychologist or psychiatrist trained in intelligence test administration and interpretation. At the hearing level, the testimony of a medical or psychological advisor or vocational expert may be required.

Test results obtained at younger ages are less reliable and valid than test results obtained at older ages. Results obtained below the age of 6 are particularly suspect. The test results should be consistent with the child's behavior and daily activities as reflected in the evidence of record, including reports of disability interviews or observations or testimony at the hearing. When there are inconsistencies further documentation may be required to resolve these differences. While there is obviously no specific age at which test results suddenly become "valid" (i.e., accurate and stable indices of the subject's abilities), IQ's obtained from tests having the desirable qualities described above tend to stabilize by the age of 16.

Recency of IQ Testing In Children

It is of utmost importance in evaluating mental deficiency that IQ test results be sufficiently current to give an accurate and realistic picture of mental capability. As indicated in section 112.00B of Part B of the Listing of Impairments, the necessary evidence in cases involving mentally retarded children includes, in addition to the results of applicable standardized psychological tests, observations by professional workers and information concerning daily activities and past and present behavior.

In evaluating whether IQ test results obtained before age 16 are sufficiently current to permit adjudication, both the child's age at the time of testing and the test results themselves should be considered. While reliability and validity are in part dependent on age at testing, very low IQ's are less likely to increase to a point in excess of 59 (at which point an individual would have an impairment that no longer meets or equals the Listing on the basis of IQ alone).

In determining whether IQ test results are sufficiently current to permit disability evaluation, the following may be considered as general guides:

	IQ Obtained Before Age 7	IQ Obtained at Age 7 or Older
IQ less than 40	Current for 2 years	Current for 4 years
IQ 40 or above	Current for 1 year	Current for 2 years

Intelligence test results obtained at age 16 or older may be assumed to apply to the subject's current status provided they are compatible with the individual's current behavior. However, when test results obtained in the past are incompatible with current behavior, current testing will be required. Current testing may also be required where the IQ results at hand fall within the range which requires an assessment of vocational factors. Such current testing (WAIS as well as other appropriate tests) may be needed to determine whether the individual can engage in any substantial gainful activity.

Verbal and Nonverbal Measures of Intelligence

Sections 12.00B and 112.00B of the Listing of Impairments describe the circumstances under which one or another of the various standardized measures of intelligence is appropriate. Intellectual abilities can generally be assigned to either of two broad categories: verbal and nonverbal (performance). Certain measures of intellectual functioning are almost exclusively verbal (e. g., the Revised Stanford-Binet Scale). Other acceptable measures of general intellectual functioning are almost exclusively nonverbal (e.g., the Raven Progressive Matrices). The Wechsler scales incorporate both verbal and nonverbal sections and yield separate IQ's for each.

For the majority of persons, scores on verbal measures tend to be highly correlated with scores on nonverbal measures, even though two, somewhat different, broad facets of intellectual functioning are involved. However, both are relevant to the determination of impairment severity.

In tests containing both verbal and performance sections, an individual may attain a marginally higher score (or in rare instances, even an appreciably higher score) on one component than on the other, but this in no way alters the fact that the severity of impaired intellectual functioning is denoted by the lower of the two scores. The full scale IQ, on the other hand, is usually a statistical average of the two, although in rare instances it can be higher (or lower) than either. Accordingly, where appropriate intelligence testing yields verbal, performance and full scale IQ's, the lowest result of the three will be determinative of impairment severity.

The Role of Subtest Scores in Psychological Reports

Inclusion of subtest scores in conjunction with the Wechsler scales is always desirable in the assessment of mental deficiency because it:

1. Provides evidence that the entire battery of subtests was administered rather than a less reliable "short-form";
2. Provides clues to a possible invalidity of test results or to possible errors in computing IQ scores; and
3. Permits the evaluation of intellectual strengths and weaknesses that may have a bearing on capacity to work where a determination cannot be made on the basis of medical considerations alone.

Moreover, reporting of subtest scores is essential in cases where cognitive deficits require assessment (e.g., chronic brain syndrome or "organicity" due to injury or disease). Since the pattern of subtest scores is most useful in providing medical evidence (signs and laboratory findings) regarding such alleged deficits, inclusion of subtest scores in such cases is required.

The absence of subtest scores in reports of psychological testing performed independently of Social Security disability evaluation does not necessarily mean that a proper determination or decision cannot be made without them. However, since it cannot be reliably determined in advance when subtest scores will be required in connection with intellectual evaluation, subtest scores should be requested when arranging to purchase consultative psychological examinations involving the Wechsler scales. In the occasional situation where administration of certain tests, subtests, or subscales may be neither feasible nor valid because of the individual's background, condition, or circumstances, it should be requested that an explanation for this limitation be included in the report. If test results (including subtest scores) are not included they should be requested, and if unavailable, further testing may be required.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCES: Program Operations Manual System, section DI 2204.

TITLES II AND XVI: MEDICAL IMPAIRMENTS THAT ARE NOT SEVERE

PURPOSE: To enunciate the policy regarding nonsevere impairments and to provide examples of impairments that are not severe in order to more clearly illustrate the level of severity required before the concept of "nonsevere impairment" can be applied in the sequential evaluation of disability.

CITATIONS (AUTHORITY): Sections 216(i), 223(d), and 1614(a)(3)(A) of the Social Security Act, as amended; Regulations No. 4, sections 404.1520 and 404.1521; and Regulations No. 16, sections 416.920 and 416.921.

PERTINENT HISTORY: Regulations No. 4, section 404.1502(a), published in 1960, introduced the principle that a denial determination may be made on the basis of medical considerations alone. It stated that:

> ". . . medical considerations alone may justify a finding that the individual is not under a disability where the only impairment is a slight neurosis, slight impairment of sight or hearing, or other slight abnormality or combination of slight abnormalities."

Sections 404.1504 and 416.904 of the regulations published in 1978 revised the 1960 statement and included a statement on work-related functions as follows:

> ". . . medical considerations alone can justify a finding that an individual is not under a disability where the medically determinable impairment is not severe. A medically determinable impairment is not severe if it does not significantly limit an individual's physical or mental capacity to perform basic work-related functions."

The meaning of work-related functions was explained in 1980 by sections 404.1521 and 416.921 of the regulations which now provide:

(a) "Nonsevere impairment. An impairment is not severe if it does not significantly limit your physical or mental abilities to do basic work activities."

(b) "Basic work activities. When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs . . . ."

Examples of basic work functions are included in sections 404.1521(b) and 416.921(b).

Throughout this period of regulatory revision, we have tried to identify medical conditions which demonstrate nonsevere impairments. Based on increasing experience and extensive consultation with disability program physicians, 20 examples of medical conditions that are not severe

have now been recognized. These 20 examples are intended to illustr
a level of impairment severity where the evaluation principle for nor
vere impairments applies. In addition, these 20 examples, while
exhaustive, represent a significant number of specific impairments t
serve as guidelines of the level of impairment severity which would w
rant a finding that an individual's impairment is not severe.

POLICY STATEMENT: In determining whether an individual is
abled, we follow a sequential evaluation process whereby current w
activity, severity and duration of impairment, residual functio
capacity (RFC), and vocational factors (age, education and work ex
ience) are considered in that order.

Built into this process is the statutory requirement that to be found
abled, an individual must have a severe medically determinable imp
ment. For an impairment to be considered severe, it must significa
limit the individual's physical or mental capacity to perform on
more basic work-related functions such as standing, walking, lift
handling, seeing, hearing, speaking, and understanding and follov
simple instructions. An impairment that does not significantly limit
capacity to perform work-related functions, as they are require
most jobs, is not severe.

At that stage in the sequential evaluation process, when we may de
that an impairment is not severe, we do not consider the effects of
education, and work experience (i.e., the vocational factors) sinc
such cases the determination is based on medical considerations al
Similarly, the individual's RFC is not assessed in cases in which
individual's impairment is determined to be not severe. In such ca
the RFC assessment is not relevant because it is based upon functi
limitations which result from a severe impairment, and, thus, it
comes into play at a later stage in the sequential evaluation process

If an individual had a highly selective job involving unusual wor
lated functions, a nonsevere impairment may prevent him or her
performing his or her previous work. However, when an individual h
"nonsevere" impairment, no serious question of inability to enga
substantial gainful activity is present because the individual w
clearly be able to perform the basic work-related functions as the
required in most jobs. The inability to perform prior work in such a
stance would arise from *both* the specific demands of the work an
impairment rather than the impairment itself.

If the individual's impairment is shown by the medical evidence
not severe in accordance with the criteria and examples described
in, that impairment cannot itself prevent performance of work-re
functions, except as they may be required in a highly selective gro
jobs. To be found disabled, an individual must have a severe med
determinable impairment. That standard cannot be satisfied by
impairment(s) that is compatible with the ability to perform basic
related functions as required in most of the numerous jobs in th
tional economy.

Inasmuch as a nonsevere impairment is one which does not significantly limit basic work-related functions, neither will a combination of two or more such impairments significantly restrict the basic work-related functions needed to do most jobs. However, when a nonsevere impairment(s) is imposed upon a severe impairment(s), the combined effect of all impairments must be considered in assessing RFC.

The following examples are merely representative of the types of impairments which would be considered not severe and are not intended to be all inclusive. In formulating these examples, the potential for severe and prolonged pain has been considered. These conditions are not expected to produce symptoms of severe and prolonged pain.

1. Musculoskeletal
   a. Osteoarthritis corroborated by X-ray findings, with symptoms of pain and stiffness of lumbar or cervical spine or major joints, and minimal abnormal findings on physical examination.
   b. Traumatic fracture of a vertebral body, in the absence of metabolic bone disease, with loss of less than 50 percent of height of the vertebra without significant physical findings or neurologic abnormalities.
   c. Excision of lumbar disc has been performed and there are no ongoing significant motor abnormalities or significant objective abnormal physical findings.
2. Special Senses
   a. Retention of best corrected visual acuity of 20/40 in the better eye (phakic) without significant restriction of visual fields.
   b. Retention of visual field in better eye of a radius of 45 degrees or better (visual field efficiency of approximately 70 percent).
3. Respiratory
   a. Obstructive airway disease where FEV_1 or MVV is greater than values shown in the table below, and there is no clinical evidence of impairment of gas exchange.

Height* (Inches)	FEV_1 (L/Min., BTPS)	MVV (MBC) (L/Min., BTPS)
60 or less	1.4	56
61-63	1.5	60
64-65	1.6	64
66-67	1.7	68

Height* (Inches)	FEV_1 (L/Min., BTPS)	MVV (MBC) (L/Min., BTPS)
68-69	1.8	72
70-71	1.9	76
72 or more	2.0	80

*Height without shoes.

b. Diffuse pulmonary fibrosis where the arterial blood gas values do not meet the requirements of Listing 3.04, table III, at an exercise level of 25 ml. 0_2/kg./min., or work equivalent.

4. Cardiovascular

a. Hypertension without significant organ damage, current or past.

b. History of chest pain without specific ischemic findings on ECG (rest and exercise), less than 50 percent narrowing on angiography, and without significant cardiomegaly.

c. Surgery has been performed for peripheral arterial disease and there are palpable pulses below the femoral level and no intermittent claudication.

5. Digestive

a. Colostomy, uncomplicated, with proper function of the stoma and nutrition adequately maintained.

b. Peptic ulcer, uncomplicated or with recovery from complications.

c. Chronic liver disease, in the absence of ascites, with total bilirubin less than 1.5 mg. per deciliter and serum albumin is 3.5 gm. per deciliter or greater.

d. Inflammatory bowel disease (regional enteritis, ulcerative colitis) in clinical remission for 12 months prior to adjudication.

6. Genito-Urinary

a. Nephrotic syndrome, in remission, with persistent mild edema in which urinary protein excretion is less than 500 mg. per 24 hours and serum albumin of 3.5 gm. per deciliter or greater.

b. Chronic renal disease (other than nephrotic syndrome) in which the serum creatinine is persistently less than 3 mg. per deciliter (100 ml.), in the absence of clinical complications.

7. Endocrine
    a. Diabetes mellitus, adult onset, controlled on prescribed therapy, without significant end-organ damage or recent episodes of acidosis.
8. Neurological
    a. Epilepsy with no major motor seizures for 12 months prior to adjudication.
    b. Peripheral neuropathy or neuritis, due to any cause, with no significant motor or sensory loss.
9. Mental Disorders
    a. IQ of 80 or greater in all major areas of intellectual functioning.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCE: Program Operations Manual System, section 2107.

(Previously Published as PPS-81)

TITLES II AND XVI: THE SEQUENTIAL EVALUATION PROCESS

PURPOSE: To state the policy regarding sequential evaluation of disability as set forth in the regulations and to explain and clarify the provisions so there is a better understanding of this policy which will result in the correct and consistent application of these provisions of the regulations.

CITATIONS (AUTHORITY): Sections 216(i), 223(d), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1510, 404.1520, 404.1521, 404.1525, 404.1526, 404.1528, 404.1545, 404.1560-404.1572, 404.1577, 404.1578 and Appendix 1; Regulations No. 16, Subpart I, sections 416.910, 416.920, 416.921, 416.925, 416.926, 416.928, 416.945, and 416.960-416.972.

INTRODUCTION: In determining whether an individual (except for a title II widow, widower, or surviving divorced spouse; or a title XVI child under age 18 or "statutorily blind" individual) is disabled, the regulations state that a sequential evaluation process is followed whereby current work activity, severity and duration of the impairment(s), ability to do past work and vocational factors are considered in that order. (To be found disabled, title II widows, widowers, or surviving divorced spouses and title XVI children under age 18 must meet or equal the Listing of Impairments in Appendix 1, Subpart P of the Regulations.) (See SSR 82-53 (PPS-74: Basic Disability Evaluation Guides).) This policy statement explains sequential evaluation by going through each step of the process. Where appropriate, cross-references are made to: (1) other PPS's which cover, in greater detail, specific steps in the process; or (2) pertinent regulatory provisions which are self-explanatory and not repeated here.

POLICY STATEMENT: If a title II or title XVI claimant is not working or his or her work does not demonstrate the ability to engage in any substantial gainful activity (SGA) during the period in which disability is al leged, we give primary consideration to the severity of the individual's impairment(s). In addition, if medical considerations alone are no determinative of the issue of disability for a title II worker or childhoo disability claimant or for a title XVI claimant age 18 or older, we con sider the ability to do past relevant work and the individual's age education, training and work experience, as they relate to the ability t perform any other work.

The following evaluation steps are followed in the sequence shown, *bu when a determination or decision that an individual is or is not disable can be made at any step, evaluation under a subsequent step is n necessary.*

Is the Individual Engaging in Substantial Gainful Activity?

When an individual is actually engaging in SGA or did so during any pertinent period, and there is no possibility of establishing a period of disability which ended prior to the date of the decision, a finding shall be made without consideration of either medical or vocational factors that the individual is not under a disability. When a title II or title XVI claimant is not (or was not) actually engaging in SGA, primary consideration is given to the severity of the individual's impairment(s). (See SSR 81-7 (PPS-55: Substantial Gainful Activity Earnings Guidelines After 1977) and SSR 81-39 (PPS-60: Determination of Substantial Gainful Activity of Employees, etc.) which further explain some of the basic concepts.)

Does the Individual Have a Severe Impairment?

A finding of ability to engage in SGA may be justified on the basis of medical considerations alone when the degree of a medically determinable impairment is found to be not severe. A not severe impairment may consist of *one or more* separate conditions that do not significantly limit the individual's physical or mental capacity to perform basic work-related functions.

Performance of basic work-related functions involves a capacity for sitting, standing, walking, lifting, pushing, pulling, handling, seeing, hearing, communicating, and understanding and following simple instructions. When there is no significant limitation in the ability to perform these types of basic work-related functions, an impairment will not be considered to be severe even though it may prevent the individual from doing work that the individual has done in the past. Inasmuch as a nonsevere impairment is one which does not significantly limit basic work-related functions, neither will a combination of two or more such impairments significantly restrict the basic work-related functions needed to do most jobs. However, when a nonsevere impairment(s) is imposed upon a severe impairment(s), the combined effect of all impairments must be considered. (See SSR 82-55 (PPS-84: Medical Impairments That Are Not Severe).)

Does the Individual Have an Impairment(s) Which Meets or Equals the Listing?

A finding of disability will ordinarily be justified when the individual's impairment is one which is as severe as the impairments contained in the Listing of Impairments. The Listing of Impairments (see Regulations No. 4, Subpart P, Appendix 1) contains over 100 medical conditions which would ordinarily prevent an individual from engaging in *any* gainful activity. The Listing helps to assure that determinations or decisions of disability have a sound medical basis, that claimants receive equal treatment throughout the country, and that the majority of persons who are disabled can be readily identified.

The level of severity described in the Listing is such that an individual who is not engaging in SGA and has an impairment or the equivalent of an impairment described therein is generally considered unable to work by reason of the medical impairment alone. Thus, when such an individual's impairment or combination of impairments meets or equals the level of severity described in the Listing, and also meets the duration requirement, disability will be found on the basis of the medical facts alone in the absence of evidence to the contrary (e.g., the actual performance of SGA, or failure to follow prescribed treatment without a justifiable reason). *The claimant's impairment(s) must meet or equal a listed impairment for a favorable determination or decision to be based on medical considerations alone.*

Evaluating Medical Equivalence—Medical Judgment Required

For an impairment to be found to be equivalent in severity to a listed impairment, the set of symptoms, signs and laboratory findings in the medical evidence supporting a claim must be compared with and found to be equivalent in terms of medical severity and duration to the set of symptoms, signs and laboratory findings specified for a listed impairment. When the individual's impairment is not listed, the set for the most closely analogous listed impairment is used.

Where an individual has a combination of impairments, none of which meets or equals a listed impairment, and each impairment is manifested by a set of symptoms and relevant signs and/or abnormal laboratory findings, the collective medical findings of the combined impairments must be matched to the specific set of symptoms, signs, and laboratory findings of the listed impairment to which they can be most closely related. The mere accumulation of a number of impairments will not establish medical equivalency. In no case are symptoms alone a sufficient basis for establishing the presence of a physical or mental impairment.

Any decision as to whether an individual's impairment or impairments are medically the equivalent of a listed impairment must be based on medical evidence demonstrated by medically acceptable clinical and laboratory diagnostic techniques, including consideration of a medical judgment about medical equivalence furnished by one or more physicians designated by the Secretary. The Disability Determination Services physician's documented medical judgment as to equivalency meets this regulatory requirement.

Interrelationship of Medical and Vocational Factors: Title II Worker or Childhood Disability Beneficiary/Title XVI Claimant Age 18 or Older

When a determination cannot be made on the basis of the medical factors alone (i.e., when the impairment falls short of the level of severity depicted by the Listing, yet there is a significant limitation in the ability to perform basic work-related functions), the sequential evaluation process must continue with consideration of the vocational factors in the claim. *A finding of ability to engage in any SGA cannot be justified solely on the grounds that the impairment does not meet or equal the level of severity depicted by the Listings.*

Evaluation under Regulations No. 4, section 404.1520(e) and (f) and Regulations No. 16, section 416.920(e) and (f) requires careful consideration of whether the individual can do past relevant work (PRW), and if not, whether he or she can reasonably be expected to make a vocational adjustment to other work. When the individual's residual functional capacity (RFC) precludes meeting the physical and mental demands of PRW, consideration of all the facts of the case will lead to a finding that (1) the individual has the functional and vocational capacity for other work, considering the individual's age, education, and work experience, and that jobs which the individual could perform exist in significant numbers in the national economy, or (2) the extent of work that he or she can do, functionally and vocationally, is too narrow to sustain a finding of ability to engage in SGA.

Since the severity of the impairment must be the primary basis for a finding of disability, this step of the evaluation process begins with an assessment of the claimant's functional limitations and capacities. Then a determination or decision must be made as to whether the individual retains capacity to perform past relevant work. An evaluation is then made of age, education, work experience and training. Consideration of the following principles will help identify the key issues for resolution with respect to these factors. No single factor should be considered as conclusive. They should be applied in combination to the range of work that remains within the claimant's RFC.

Whether the claimant retains the functional capacity to perform work which he or she has done in the past has far-reaching implications and should be developed and explained fully in the disability determination or decision. Neither the determination or decision nor the denial notice should concede inability to do past work unless there is adequate documentation to establish the fact. Since this is an important and, in some instances, a controlling issue, every effort should be made to secure evidence that resolves the issue clearly and explicitly.

The vocational factors as well as RFC are described in detail as follows:

- *RFC*—RFC is the remaining ability to perform work-related physical and mental activities. The claimant's functional capacity must be defined in terms of the claimant's ability to function in a work setting. When multiple impairments are involved, the assessment of RFC reflects the restrictions resulting from all impairments (both severe and not severe impairments). This assessment is based on all relevant evidence pertaining to RFC consistent with appropriate clinical and laboratory findings.

  Assessment of physical capacities (e.g., strength and exertional capabilities) includes an evaluation of the individual and indicates his or her maximum RFC for sustained activity on a regular basis. Such assessment also includes an evaluation of the ability to perform significant physical functions such as walking, standing, lifting, carrying, pushing, or pulling, and such other physical traits and sensory characteristics as reaching, handling, seeing, hearing, and speaking insofar as limited capacity to perform these activities may affect the individual's capacity for work for which he or she would otherwise be qualified.

Any medically determinable impairment(s) not resulting in exertional limitations (such as certain mental, sensory or skin impairments) must be considered in terms of the limitations resulting from the impairment. When an individual has such impairment(s) in addition to an exertional impairment(s), remaining functional capacity must be assessed in terms of the degree of any additional narrowing of the individual's work-related capabilities. The assessment of impairments because of mental disorders includes consideration of such factors as the ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and customary work pressures in a routine work setting.

The RFC assessment is based primarily on the medical findings, i.e., the symptoms, signs, and laboratory results, which must be complete enough to permit and support the necessary judgments concerning the individual's physical, mental, and sensory capacities and any environmental restrictions. Descriptions and observations of the claimant's restrictions by medical and nonmedical sources in addition to those made during formal medical examinations must also be considered in the determination of RFC.

Where no issue with respect to specific physical or mental capacities is raised by the allegations of the individual or the evidence obtained, the individual is considered to have no restrictions with respect to those capacities. The individual has the burden of proving that he or she is disabled and of raising any issue bearing on that determination or decision.

For the purpose of determining the exertional requirements of work in the national economy, jobs are classified as "sedentary," "light," "medium," "heavy," and "very heavy." Such terms have the same meanings as are used in the *Dictionary of Occupational Titles*, published by the Department of Labor (DOL), and when used in making disability determinations or decisions are used as follows: sedentary work, light work, medium work, heavy work, and very heavy work. In order to evaluate the claimant's skills and to help determine the existence in the national economy of work the claimant is able to do, occupations are classified as unskilled, semiskilled, and skilled. For classifying these occupations, materials published by the DOL are used.

- *Age*—The term "age" refers to chronological age and the extent to which it affects the individual's ability to adapt to a new work situation and engage in work in competition with others. Reference sources and materials dealing with chronological age in terms of vocational impact point to a direct relationship between age and the ability to adjust to other work.

  These sources and materials reflect employment problems developing at age 45 and the problems becoming significantly intensified at age 55. Thus, the regulations reflect age 55 and over as "advanced age," representing the point when age could be expected to be an adverse consideration in determining an individual's vocational adaptability to work differing from that of his or her past experience. However, disability is *never* determined on the basis of age alone. The following age classifications are established in Regulations Nos. 4 and 16 (see sections 404.1563 and 416.963): younger person, person approaching advanced age, and person of advanced age. These designations of age are an expectancy only, not arbitrary limits, and may not be crucial in a particular case. Age categories are not applied mechanically in borderline cases.

- *Education and Training*—Education generally refers to formal schooling; training refers to skills and knowledge acquired on the job or through general experience in an industry or field of work. Both can significantly affect ability to work, and must therefore be considered in evaluating the impact of an impairment on an individual claimant. (Regulations Nos. 4 and 16, sections 404.1564 and 416.964, establish the following classifications of educational levels: illiteracy, marginal education, limited education, high school and above, and inability to communicate in English.)

  Training that is vocationally significant prepares an individual to do a specific job or provides background to do a number of jobs in the same field. Training that is not reflected in the individual's actual work experience would raise questions as to its adequacy and current usefulness to the individual. Content, duration, and recency should be considered in determining the scope and application of training and its current usefulness. Normally, if an individual completed training more than 15 years prior to the point at which the claim is being considered for adjudication (or when the earnings requirement was last met if earlier) and did not make use of it in his or her work, it would not affect the claimant's vocational outlook at the present time. Moreover, even if completed within the 15-year period, training would not ordinarily be expected to qualify an individual for more than entry level (e.g., at the apprenticeship or lowest beginning level) occupations. Therefore, care should be exercised to assure that undue weight is not attributed to training and to ascertain how training can be utilized in occupations.

- *Experience*—The jobs a person has done, the length of time spent at them, and the recency of the work are major factors in determining his or her ability to work. Work experience is relevant when it was performed within the pertinent 15-year period, lasted long enough for the individual to learn the job, and consisted of SGA. Work experience must be examined in the light of available knowledge of the physical and skill demands of different kinds of work in order to evaluate the effect of the impairment on the person's ability to return to past relevant work or to utilize remaining capacities in other jobs. (For a more detailed discussion of prior work experience, see SSR 82-62 (PPS-80: A Disability Claimant's Capacity to Do Past Relevant Work).)

The RFC assessment is used to determine whether an individual can perform past relevant work or considering an individual's age, education and work experience, other work which exists in the national economy.

- *Capacity to Do Past Relevant Work*—The RFC to meet the physical and mental demands of jobs a claimant has performed in the past (either the specific job a claimant performed or the same type of work as it is customarily performed throughout the economy) is generally a sufficient basis for a finding that the individual is not disabled. Past work experience should be considered carefully to assure that the available facts support conclusions regarding the claimant's ability or inability to perform this work.

  Where an individual with a marginal education and long work experience of 35 years or more limited to the performance of arduous unskilled physical labor is not working, and is no longer able to perform such labor because of a severe impairment(s), such an individual will generally be found to be disabled. (See Regulations Nos. 4 and 16, sections 404.1562 and 416.962.) Also a person generally will be found disabled if he or she has a severe impairment of any nature, is of advanced age, has a limited education, and has no relevant work experience.

  If the individual is able to meet the physical and mental demands of past relevant work, he or she should be found not disabled. However, the inability to do past relevant work is not in itself a basis for a finding of disability.

- *Capacity to Do Other Work*—If an individual cannot perform any past relevant work because of a severe impairment(s), but the remaining physical and mental capacities are consistent with meeting the physical and mental demands of a significant number of jobs (in one or more occupations) in the national economy, and the individual has the vocational capabilities (considering age, education, and past work experience) to make an adjustment to work different from that performed in the past, it shall be determined that the individual is not disabled.

> However, if an individual's physical and mental capacities in conjunction with his or her vocational capabilities (considering age, education and past work experience) do not permit the individual to adjust to work different from that performed in the past, it shall be determined that the individual is disabled.

The assessment ability to engage in SGA involves the evaluation of such factors as the functional capacity to perform the physical or mental exertion of work and to sustain work at a level which meets the standards of SGA on a regular and continuing basis. In all such cases where a determination or decision regarding disability is to be made, the evidence must be sufficient to permit a comparison between the claimant's capabilities and limitations and the requirements of relevant occupations.

The regulations require that, at this point in the sequential evaluation process, the rules established in Appendix 2 to Subpart P of Regulations No. 4 must be used to direct or to guide the determination as to whether the individual is "disabled." Where all factors relative to an individual coincide with those in a rule in the Appendix, that rule directs a conclusion as to whether the individual is "disabled." When all factors do not coincide with a rule (e.g., the individual has the RFC for more than light work but for less than the full range of medium work), the rules are used as a frame of reference for determining whether the individual is "disabled."

Similarly, when an individual has a combination of exertional and nonexertional impairments, the rules are used as a frame of reference for determining "disability." The exertional impairment is considered first under the applicable rule, and then the additional restriction(s) imposed by the nonexertional impairment is considered.

When an individual has a solely nonexertional impairment, the principles established in the regulations are applied in determining "disability," giving consideration to the rules for specific case situations described in Appendix 2 (i.e., use of the rules as a frame of reference). When the nonexertional impairment is a mental impairment, the ability to concentrate, to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and pressures in a work setting are considered. (See Regulations Nos. 4 and 16, sections 404.1545(c) and 416.945(c).)

The Disability Determination or Decision

The disability determination or hearing decision must be set forth carefully. The rationale must reflect the sequential evaluation process; describe the weight attributed to the pertinent medical, nonmedical and vocational factors in the case; and reconcile any significant inconsistencies. Reasonable inferences may be drawn, but presumptions, speculations and suppositions should not be substituted for evidence.

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If the determination or decision is based on medical-vocational considerations, it must always contain findings that the individual is not engaging in SGA; there is a severe impairment, but that the individual's impairment(s) does not meet or equal that of any impairment described in the Listing of Impairments; must describe the individual's specific RFC; and must sequentially relate it to physical and mental demands of past work or other substantial work to which the individual could or could not be expected to make a vocational adjustment by reason of her or his age, education and past work experience. Each finding of fact must be based on supporting evidence.

In the rationale for a denial, a mere conclusion that "the impairment(s) is not severe enough to prevent the claimant from engaging in SGA" is insufficient. If the evidence establishes that the impairment(s) is "not severe," the rationale *must* show that the impairment(s) would not significantly affect the performance of basic work-related functions. If a denial may not be made on this basis, the rationale must reflect the remainder of the sequential evaluation process.

Similarly, an allowance based on a mere conclusion that the claimant is "not able to engage in SGA" is insufficient. The rationale *must* state fully the reasons for the inability to engage in SGA based on the evidence of record, the applicable regulations, and the determinative step in the sequential evaluation process. Under the regulations, a finding that an individual's impairment(s) does not meet or equal the Listing effectively indicates that he or she has a sufficient work capability at the sedentary or a higher exertional level, to require medical-vocational evaluation. Therefore, an allowance determination or decision based on a conclusion that "the claimant has no RFC" is never appropriate. If the impairment(s) does not meet or equal the Listing, the rationale *must* reflect the remainder of the sequential evaluation process. If the claimant does not, in fact, have the RFC for a full range of sedentary work, the case must be evaluated within the framework of the vocational rules. The functional restrictions which limit the claimant to less than the full range of sedentary work must be specified. It must then be determined whether, considering all of the functional limitations, a "significant number" of sedentary jobs which the claimant can perform exists in the national economy.

Where denial is on the basis of duration, if based on medical-vocational considerations, the projected RFC must similarly be described and related.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCES: Program Operations Manual System, sections DI 2102-2102B, 2103, 2105, 2380, and 2383.

TITLES II AND XVI: LOSS OF SPEECH

PURPOSE: To state the policy and describe the necessary elements for the evaluation of organic loss of speech when determining disability under titles II and XVI of the Social Security Act.

CITATIONS (AUTHORITY): Sections 223(d), 216(i), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, section 404.1525, and Appendix 1, Part A, sections 2.00.B.3, 2.09 and 11.00-11.19; and Regulations No. 16, Subpart I, section 416.925.

INTRODUCTION: Regardless of the cause of organic loss of speech, disability occurs when the individual is unable, by any means, to produce speech which can be heard, understood, and sustained. This policy statement explains in detail how loss of speech is to be evaluated. Functional loss of speech is addressed in sections 2.00.B.3 and 2.09 of the Listing of Impairments. Neurological disorders resulting in loss of speech are evaluated under sections 11.00-11.19. (Note: Medical criteria for evaluating impairments for children under age 18 are generally contained in Part B of the Listing. When a particular impairment is not included in the "childhood listings," it should be evaluated under Part A of the Listing.)

POLICY STATEMENT: Ordinarily, when an individual's impairment prevents effective speech, the loss of function is sufficiently severe so that an allowance under Listing 2.09 is justified on the basis of medical considerations alone, unless such a finding is rebutted by work activity. To speak effectively, an individual must be able to produce speech that can be heard, understood, and sustained well enough to permit useful communication in social and vocational settings. These criteria are applicable to the production of speech whether by natural function of the voice mechanism or by the use of a prosthetic device.

Three attributes of speech pertinent to the evaluation of speech proficiency are: (1) audibility—the ability to speak at a level sufficient to be heard; (2) intelligibility—the ability to articulate and to link the phonetic units of speech with sufficient accuracy to be understood; and (3) functional efficiency—the ability to produce and sustain a serviceably fast rate of speech output over a useful period of time. When at least *one* of these attributes is missing, overall speech function is not considered effective.

When a refined assessment of speech proficiency is necessary, it should be made by an otolaryngologist or a speech therapist whose evaluation should be based *both* on personally listening to the claimant's speech and on a history of the claimant's performance in everyday living. The findings should be sufficient to provide the reviewer with a clear picture of the individual's speech capacity. Such an analysis covering the attributes of speech discussed above would include a detailed description of the following points:

1. *The intensity of speech (audibility)*—the conditions under which the individual can and cannot be heard (e.g., in quiet surroundings, noisy places, a moving automobile); the maximum distance at which individuals can be heard; whether their voices tend to become inaudible, and if so, after how long;
2. *The ability to articulate (intelligibility)*—the frequency of any difficulties with pronunciation, the extent to which the individual is asked to repeat, how well he or she is understood by strangers unaccustomed to hearing esophageal speech; and
3. *The rate of speech and the degree of ease with which the individual's speech flows (functional efficiency)*—how long he or she is able to sustain consecutive speech; the number of words spoken without interruption or hesitancy; whether he or she appears fatigued, and if so, after how long.

If medical considerations alone are not determinative of the issue of disability for a title II worker or childhood disability claimant or for a title XVI claimant age 18 or older, consider the individual's vocational factors (age, education, training and work experience) as these factors relate to the ability to perform past relevant work or any other work.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCE: Program Operations Manual System, section DI 2202.

TITLES II AND XVI: EVALUATION OF SYMPTOMS

PURPOSE: To state the policy and describe the consideration given to symptoms, particularly that of pain, in the evaluation of disability under titles II and XVI of the Social Security Act.

CITATIONS (AUTHORITY): Sections 223(d), 216(i), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, sections 404.1508, 404.1528, and 404.1529; and Regulations No. 16, sections 416.908, 416.928, and 416.929.

INTRODUCTION: Symptoms such as pain, shortness of breath, weakness, or nervousness are the individual's own perceptions of the effects of a physical or mental impairment(s). Because of their subjective characteristics and the absence of any reliable techniques for measurement, symptoms (especially pain) are difficult to prove, disprove, or quantify. This policy statement explains the consideration to be given to symptoms in the evaluation of impairment severity and functional limitation. It emphasizes the need for a sound medical basis to support the overall evaluation of impairment severity and underscores the importance of detailed findings from reporting medical sources when the consideration of symptoms may be a significant part of functional capacity assessment.

POLICY STATEMENT: Symptoms will not have a significant effect on a disability determination or decision unless medical signs or findings show that a medical condition is present that could reasonably be expected to produce the symptoms which are alleged or reported. However, once such a medical condition (e.g., disc disease) is objectively established, the symptoms are still not controlling for purposes of evaluating disability. Clinical and laboratory data and a well-documented medical history must establish findings which may reasonably account for the symptom in a particular impairment. Objective clinical findings which can be used to draw reasonable conclusions about the validity of the intensity and persistence of the symptom and about its effect on the individual's work capacity must be present. For example, in cases of back pain associated with disc disease, typical associated findings are muscle spasm, sensory loss, motor loss, and atrophy. There must be an objective basis to support the overall evaluation of impairment severity. It is not sufficient to merely establish a diagnosis or a source for the symptom.

When symptoms are alleged as a significant aspect of the impairment but the criteria for a listed impairment are not met or equalled and a severe impairment exists, the symptoms must be considered in evaluating disability and must be addressed in the disability determination or decision. The following sequential evaluation process facilitates that consideration.

Need to Establish a Medically Determinable Severe Impairment

To be found disabled under the law, an individual must have a medically determinable severe impairment, i.e., an impairment which has demonstrable anatomical, physiological or psychological abnormalities. Such abnormalities are medically determinable if they manifest themselves through medical evidence consisting of symptoms, signs, and laboratory findings. Symptoms alone, however, do not constitute a basis for finding a medically determinable impairment.

If no medically determinable *physical* impairment is found, yet the person alleges work-related limitations due to a symptom normally attributable to a physical impairment, the possibility of a medically determinable severe *mental* impairment must be considered. When a medically determinable severe impairment cannot be established on either a physical or a mental basis, the claim must be denied, regardless of the intensity of the symptom, related limitations alleged, or any judgments by examining medical sources about the effects of the symptom. (See SSR 82-55 (PPS-84: Medical Impairments That Are Not Severe).)

Decide Whether the Listing is Met or Equalled

When a medically determinable severe impairment is documented, the next step is to determine whether the Listing of Impairments is met or equalled. The Listing or Impairments includes requisite symptoms in certain circumstances. In determining whether a listed set of criteria which includes a symptom as one criterion is met, ordinarily it is essential only that the symptom(s) be present, *in combination* with the required clinical signs and laboratory findings. Unless specifically stated in the Listing, quantification or other evaluation of the degree or functionally limiting effects of that symptom is not required to determine whether the criteria of a listed impairment are met.

If the listed criteria are not met, consider whether the impairment equals a set of symptoms and findings in the Listing. However, if the requisite clinical signs and laboratory findings, or other findings of equal or greater significance are not present, the symptom cannot be persuasive that the Listing is met or equalled. *No alleged or reported intensity of the symptoms can be substituted to elevate impairment severity to equivalency.* For example, if pain is present and is a requisite for a listed impairment, but one (or more) of the requisite clinical or laboratory findings for meeting the Listing is missing or are of a lesser value, complaints of "severe," "extreme," or "constant" pain will *not* compensate for the missing medical findings and permit an "equals" determination.

Determine the Impact of Symptoms on Residual Functional Capacity

When the listed impairment criteria are not met or equalled but one or more impairments are severe, a residual functional capacity (RFC) assessment must be made. In assessing symptoms such as pain as a factor of RFC, the functionally limiting effects of the symptom can play a significant role. The effects of symptoms must be considered in terms of any additional physical or mental restrictions they may impose beyond those clearly demonstrated by the objective physical manifestations of disorders. Symptoms can sometimes suggest a greater severity of impairment than is demonstrated by objective medical findings alone. However, since symptoms, such as pain, are subjective and cannot be quantified by any reliable method, any additional symptom-related functional limitations must largely be inferred from the history and the objective physical findings (e.g., reduced joint motion, muscle wasting, muscle spasm, sensory and motor disruption, etc.) and from medical knowledge as to what symptom-related effects on functional capacity can be reasonably expected. In assessing allegations of disabling symptoms, consideration should be given to data such as the alleged frequency and duration of the symptom (with pain, location and radiation); precipitating or aggravating factors; effect on daily activities; and dosage, effectiveness, and side-effects of medication; as well as any recorded observations about symptoms by persons such as examining physicians and Social Security Administration employees (district office representatives, administrative law judges, etc.). Reasonable conclusions can be drawn from such information concerning both the presence and persistence of the symptom and its effects and any resultant additional diminution of RFC. The absence of such history and objective clinical findings, with few exceptions, will be inconsistent with a conclusion that the symptom diminishes functional capacity.

There may be an emotional component to all symptoms, but the fact that an individual may seem to be exaggerating the limitations arising from a symptom does not necessarily mean that the symptom or the alleged functional limitation is in any way the result of an emotional disorder. However, when alleged symptom-related limitations are clearly out of proportion to physical findings (e.g., no clinical findings of severe neuromuscular disorder, yet the individual alleges inability to stand, bend, or walk due to constant pain), the *possibility* of a severe mental impairment should be investigated. Consequently, if there are unconfirmed but alleged significant functional limitations and medical evidence received from treating and examining medical sources does not resolve whether a severe mental impairment is present, we will consider obtaining a psychiatric evaluation.

When a severe psychiatric impairment is demonstrated, conclusions about the significance of pain, or of any other symptom of emotional origin, will be based on the determination of the severity of the mental impairment and the resultant limitation of activities, interests, personal habits, and ability to relate to others.

Thorough and comprehensive RFC assessments become most critical in denial determinations and decisions, when the persistence or the extent of alleged or reported symptom-related limitations is (1) not consistent with the severity of the physical impairment which has been established and (2) not explainable on a psychiatric basis. In those situations it is essential to identify and resolve all conflicting medical source conclusions and claimant allegations about functional capacity. The RFC assessment must convey the reason(s) why the alleged or reported symptom-related functional limitation is not supported by the evidence. Statements by the treating/examining sources or by the individual which are consistent with the ultimate conclusion as to functional capacity should also be included in the RFC discussion. (See SSR 82-30 (PPS-64: Responsibility for Residual Functional Capacity Assessments).)

The following examples show the kind of information and discussion which should be included in RFC statements in cases involving the symptom of pain. In the second example the individual can do a full range of light jobs, while in the first example the individual can only do a full range of sedentary jobs.

1. Effects of Pain Supported by the Evidence

   History of a ruptured disc, with a hemilaminectomy and disc excision at L4-5. Postoperatively, continues to have back pain. Repeated examinations to date reveal consistent findings, including limitation of forward bending of the spine to 45 degrees; extension to 5 degrees; no limp on walking or significant difficulty in heel or toe walking; difficulty in climbing on to examining table, with back pain when lying flat; straight-leg raising positive at 30 degrees on right, 70 degrees on left; depressed right achilles reflex; marked tenderness over right lumbar spine, with marked spasm of the paraspinal muscles; increased back pain on forward flexion, with splinting of lower spine to the left; no motor or sensory loss or other neurological abnormality. Wears a chairback brace and takes 8-10 aspirin daily and codeine occasionally.

   Treating physician states that pain is a significant factor in the individual's current activity restrictions and that he advised the claimant to avoid lifting heavy or bulky objects. In addition, claimant states that the continued pain prevents walking more than two blocks, prevents his lifting of his 2-year-old grandson, and limits him to light household chores.

   The objective findings, by themselves, support a conclusion that the individual should not lift or carry more than 50 lbs. or frequently lift or carry more than 25 lbs. Frequent bending is also precluded. The clinical findings are consistent with both the complaints of pain and with the individual's stated limitations. Therefore, it is concluded that, due to pain, the individual's functional capacity to stand and walk is restricted to less than 6 hours (but more than 2 hours) per day. Sitting is unlimited.

Although the individual's lifting and carrying ability is part of medium work, the vast majority of medium jobs also would require being on one's feet for a total of about 6 hours of an 8-hour workday, with frequent bending at the waist as well as bending of the knees. Since the individual cannot do frequent bending and further can stand and walk only between 2 and less than 6 hours a day, most jobs at both the medium and light levels of exertion are ruled out by the effects of the impairment. Jobs compatible with the RFC would be those at the sedentary level of exertion, as well as light and medium jobs which are performed in a seated position.

2. Effects of Pain Unsupported by the Evidence

History of disc excision at L3-4 2 years ago; subsequent disc excisions at L4 and L5-S1, with spinal fusion of L3-S1. Current examination by treating physician shows forward bending of the spine to 50 degrees, extension to 10 degrees; all movements guarded but no actual difficulty in heel and toe walking or climbing on to the examining table; complaints of back pain on straight-leg raising at 60 degrees bilaterally, but no radiation of pain into legs; moderate tenderness to deep palpation of lumbar paraspinous muscles, but no muscle spasm; no sensory or motor loss; absent left achilles reflex, but no other neurological deficit; leg circumferences equal; X-rays show solid fusion with no movement; wears chairback brace and takes 15-20 aspirin daily, Darvon 4X daily.

Treating physician states that there is no psychiatric condition (the evidence supports this) and that spinal fusion and continued complaints of back pain alone prevent all work activity indefinitely. Claimant states that he has constant pain, worse on walking or standing, and is unable to do any household chores.

On the basis of spinal fusion, lifting and carrying is limited to 50 lbs. Frequent lifting and carrying is limited to 25 lbs. Activities involving frequent bending of the back are precluded. In spite of the claimant's statements and the physician's opinion, the objective medical evidence establishes the absence of any findings (e.g., muscle spasm, sensory or motor loss, leg pain, or muscle wasting, etc.) that are typically associated with functionally limiting back pain. Although claimant does have back pain, the medical evidence, including physical examination, demonstrates no pain-related physical or functional limitations beyond those imposed by the effects of the spinal fusion. The capacity to stand, walk, and sit is unlimited.

Here, again, the capacity to lift 50 lbs. maximum with frequent lifting or carrying of objects weighing up to 25 lbs. is part of medium work capacity. However, this is compromised by inability to bend the back frequently. Having unlimited capacity to stand walk, and sit, and being able to meet the lifting and carrying demands of light work, where frequent bending of the back is not required for the majority of light jobs, the individual can be expected to do sedentary work and substantially all light jobs. He could also do medium jobs which are performed in a seated position or which do not require frequent stooping or bending (such as might have been the case in a past job).

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCE: Program Operations Manual System, section DI 2205.

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TITLES II AND XVI: FAILURE TO FOLLOW PRESCRIBED TREATMENT

PURPOSE: To state the policy and describe the criteria necessary for a finding of failure to follow prescribed treatment when evaluating disability under titles II and XVI of the Social Security Act and implementing regulations.

CITATIONS (AUTHORITY): Sections 216(i), 223(d), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, section 404.1530; Regulations No. 16, section 416.930.

INTRODUCTION: Individuals with a *disabling impairment* which is amenable to treatment that could be expected to restore their ability to work must follow the prescribed treatment to be found under a disability, unless there is a justifiable cause for the failure to follow such treatment. This policy statement discusses failure to follow prescribed treatment, explains in detail the requirements necessary for such a finding, explains the consequences of such action, and illustrates examples of justifiable causes for "failure."

POLICY STATEMENT: An individual who would otherwise be found to be under a disability, but who fails without justifiable cause to follow treatment prescribed by a treating source which the Social Security Administration (SSA) determines can be expected to restore the individual's ability to work, cannot by virtue of such "failure" be found to be under a disability. (See discussion below for title XVI "blindness" cases.)

Identifying "Failure" as an Issue

SSA may make a determination that an individual has failed to follow prescribed treatment only where all of the following conditions exist:

1. The evidence establishes that the individual's impairment precludes engaging in any substantial gainful activity (SGA) or, in the case of a disabled widow(er) that the impairment meets or equals the Listing of Impairments in Appendix 1 of Regulations No. 4, Subpart P; and
2. The impairment has lasted or is expected to last for 12 continuous months from onset of disability or is expected to result in death; and
3. Treatment which is clearly expected to restore capacity to engage in any SGA (or gainful activity, as appropriate) has been prescribed by a treating source; and
4. The evidence of record discloses that there has been refusal to follow prescribed treatment.

Where SSA makes a determination of "failure," a determination must also be made as to whether or not failure to follow prescribed treatment is justifiable.

Treatment Must be Prescribed by Claimant's Treating Source

A treating source(s) is any duly licensed physician(s) who is actually a tending to the claimant's or beneficiary's medical needs. Where the i dividual does not have an attending physician, the treating physician(in the hospital, clinic, or other medical facility where the individu goes for medical care will be considered the treating source.

A Disability Determination Services (DDS) staff physician is not a trea ing source. Similarly, a physician whose only relationship to the clair ant is as a consulting examiner may *not* be considered a treating sourc Therefore, where a consulting examiner's findings establish severity ar for the first time indicate that specific treatment can be expected to r store ability to engage in any SGA (or gainful activity, as appropriate the case should not be denied for failure to follow prescribed trea ment. The DDS will refer such cases to the vocational rehabilitatic (VR) agency for further action.

Treatment Expected to Restore Ability to Work

While it is a treating source who must prescribe treatment in order f the issue of "failure" to arise, the judgment as to whether prescribe treatment can be expected to restore ability to work will be made l SSA. In the event the treating source states that prescribed treatme will restore ability to work, consideration should be given to such opi ion. However, if despite such opinion SSA determines that ability to e gage in SGA may not reasonably be expected to be restored, there is r issue of failure to follow prescribed treatment.

Where SSA believes that treatment might restore an individual's abili to engage in any SGA (or gainful activity, as appropriate), but no trea ing source has prescribed such treatment, a determination of allowan will be made, and the DDS will refer the individual to VR. When a hea ing or appeals council (AC) decision is issued, the administrative la judge or AC will follow established procedure to request the effectu ing component to make such referral if a question of restorative tre ment is involved.

Development of Failure to Follow Prescribed Treatment

Where the treating source has prescribed treatment clearly expected restore ability to engage in any SGA (or gainful activity, as appropriat but the disabled individual is not undergoing such treatment, approp ate development must be made to resolve whether the claimant beneficiary is justifiably failing to undergo the treatment prescribed.

Development With the Claimant or Beneficiary—The claimant or bene ciary should be given an opportunity to fully express the specific re son(s) for not following the prescribed treatment. Detailed questioni may be needed to identify and clarify the essential factors of refus

The record must reflect as clearly and accurately as possible the claimant's or beneficiary's reason(s) for failing to follow the prescribed treatment.

Individuals should be asked to describe whether they understand the nature of the treatment and the probable course of the medical condition (prognosis) with and without the treatment prescribed. The individuals should be encouraged to express in their own words why the recommended treatment has not been followed. They should be made aware that the information supplied will be used in deciding the disability claim and that, because of the requirements of the law, continued failure to follow prescribed treatment without good reason can result in denial or termination of benefits. Particular care should be taken to avoid any impression that SSA is attempting to influence the individual's decision. No statements should be made which could be construed in any way as interference with the doctor-patient relationship.

Development With Treatment Source—After documenting the claimant's or beneficiary's statements concerning the refusal of treatment, it may be necessary to recontact the treating source to substantiate or clarify what the individual was told. If possible such contacts should be made by the DDS staff physician.

The nature of the information requested from the treating source will vary according to the circumstances of the case. For instance, where the claimant or beneficiary alleges that a physician has advised that the chances of obtaining good surgical results are poor, ask the treating physician what the individual was told about the prognosis with and without treatment and elicit information regarding the individual's reaction to accepting such treatment.

Where the claimant fears undergoing prescribed surgery, the treating physician should be informed of this fact and asked about his or her current recommendation(s) for treatment. If the treating source decides against surgery, there is no issue of "failure" unless the patient refused to cooperate in an alternative recommended course of treatment, which was expected to restore the individual's ability to work.

Justifiable Cause for Failure to Follow Prescribed Treatment

Under circumstances such as those described below, an individual's failure to follow prescribed treatment will be generally accepted as "justifiable" and, therefore, such "failure" would not preclude a finding of "disability" or that disability continues.

1. *Acceptance of prescribed treatment would be contrary to the teachings and tenets of the claimant's or beneficiary's religion.* A finding of disability would be in order where the evidence establishes that the disabled individual rejects prescribed treatment on the grounds that he or she is a member of a church which teaches that healing may be accomplished only through faith or prayer.

In such a case, the claimant or beneficiary must be asked to identify church affiliation. In addition, a statement or other information from either church authorities or other members of the religious order must be obtained to substantiate that the individual is a member of the church. Additionally, the church's position relative to medical treatment must ordinarily be documented (see note below for exception) by obtaining either church literature or a statement from church authorities concerning the teachings and tenets of the church.

NOTE: In Christian Science cases, it is not necessary to develop church teachings since it is well established that such teachings proscribe acceptance of medical treatment. In these cases, a statement by a Christian Science practitioner or church authority verifying the individual's membership suffices.

2. *Cataract extraction for one eye is prescribed but the loss of visual efficiency in the other eye is severe and cannot be corrected through treatment.*

3. In an unusual case, a claimant's or beneficiary's fear of surgery may be so intense and unrelenting that it is, in effect, a contraindication to surgery. *If a treating source who had advised surgery later decides that the individual's fear is so great that the individual is not a satisfactory candidate for surgery, there is no issue of "failure."*

   Where fear of surgery is suggested to be extreme, but the treating source has limited contact with the person and is unable to indicate the significance of the fear, an independent examination by a psychiatrist may be warranted as a means of resolving whether the fear contraindicates surgery.

   Attendant to allegations of fear, it is not uncommon to see surgery refused on the grounds that the absolute success of such treatment has not been "guaranteed." No physician can guarantee the results of a major surgical procedure since any surgery generally entails some degree of risk. An individual may also attempt to justify refusal of surgery on the grounds of alleged personal or third party knowledge of persons who did not improve, or perhaps worsened, following surgery similar to that recommended to the individual by a treating physician. However, such reason(s) for nonacceptance of surgical treatment will not, in and of itself, negate a finding of "failure."

4. *The individual is unable to afford prescribed treatment which he or she is willing to accept, but for which free community resources are unavailable.* Although a free or subsi-

dized source of treatment is often available, the claim may be allowed where such treatment is not reasonably available in the local community. All possible resources (e.g., clinics, charitable and public assistance agencies, etc.), must be explored. Contacts with such resources and the claimant's financial circumstances must be documented. Where treatment is not available, the case will be referred to VR.

5. *Any duly licensed treating medical source who has treated the claimant or beneficiary advises against the treatment prescribed for the currently disabling condition.* Thus, if a person has two treating sources who take opposing views regarding treatment, one recommending and one advising against the same treatment, failure to follow the recommended treatment was justifiable. (Where an individual chooses to follow treatment recommended by one treating source, to the exclusion of alternative treatment recommended by one or more other treating sources, the issue of "failure" does not arise.)
6. *The claimant or beneficiary is presently unable to work because of a condition for which major surgery was performed with unsuccessful results, and additional major surgery is prescribed for the same impairment.*
7. *The treatment carries a high degree of risk because of the enormity or unusual nature of the procedure* (e.g., organ transplant, open heart surgery).
8. *The treatment recommended involves amputation of an extremity* (e.g., amputation at or above the tarsal region).

The specific reasons listed above are not all-inclusive as acceptable justifications for refusing to accept prescribed treatment. A full evaluation must be made in each case to determine whether the individual's reason(s) for failure to follow prescribed treatment is justifiable.

Adjudication

Based on the evidence in file, SSA may decide that it appears that the claimant or beneficiary does not have a good reason for failing to follow treatment as prescribed by a treating source and that the treatment is expected to restore ability to engage in any SGA (or gainful activity, as appropriate). However, before a determination is made, the individual, or in the case of incapable individuals the person acting on their behalf, will be informed of this fact and of its effect on eligibility for benefits. The individual will be afforded an opportunity to undergo the prescribed treatment or to show justifiable cause for failing to do so.

It is very important that the individual fully understand the effects of failure to follow prescribed treatment. In many cases, an adverse determination on this basis will mean that the individual will not later be able to meet the requirements for entitlement even if he or she has undergone or proposes to undergo treatment. This is because at the time when the individual agrees to follow prescribed treatment, such requirements as duration (see SSR 82-52 (PPS-89: Duration of the Impairment)) or insured status may no longer be met. (See discussion below under "Effect of Adverse Determination on Subsequent Decisions.")

Initial Claim—If a determination is made that within 12 months of onset failure to follow prescribed treatment has occured and it is not justifiable, the claim must be denied because the duration requirement is not met. If the determination is made that "failure" did not occur until at least 12 months after onset, a period of disability may be established, with payment of benefits to continue as usual through the second month after the month disability ends.

The issue of failure to follow prescribed treatment should be resolved as quickly as possible. However, in a case where the issue of "failure" arises or remains unresolved 12 months after onset, an allowance is in order. The issue of "failure" and if it is justifiable will continue to be developed. If the issue of "failure" arises at the hearing or AC levels, if not fully developed through testimony and/or evidence submitted, and it has been 12 months after onset, a favorable decision will be issued, and the case will be referred for development of failure to follow prescribed treatment.

Continuing Disability—The issue of "failure" may arise at the time of a continuing disability investigation where (1) subsequent to a prior favorable determination based on information indicating the individual was cooperating with prescribed treatment, the individual failed to follow through on such treatment or (2) treatment has been prescribed since the last determination. Such situations will require the same documentation as that outlined above to determine if "failure" exists and if it is justifiable. Benefits will be continued for 2 months after the month in which a determination of cessation occurs.

Effect of Adverse Determination on Subsequent Decisions

Once a claim has been denied, a closed period of disability established, or benefits terminated on the basis of failure to follow prescribed treatment, the fact that the individual may later undertake to follow such treatment will not be the basis for revising the adverse determination to establish an onset during the period the individual was not following prescribed treatment. For the determination to be revised establishing such an onset, it must be shown, with or without additional evidence, that the determination based on "failure" was incorrect. For example, if at the time of the adverse determination a treating source did not actually prescribe treatment, or the prescribed treatment could not have been expected to restore a capacity for any SGA (for gainful activity, as appropriate) or a justifiable cause for failure to follow prescribed treatment did exist, consideration of revision would be warranted. Where re vision is not warranted, and if entitlement is established, the onset date could be that date when the claimant first arranged to follow prescribed treatment. For entitlement to benefits, the impairment must then not only meet the severity requirement but also be expected to last 12 continuous months from the onset date thus established. Also, the insured status and other nondisability requirements must be met. It is very possible that most such claims will be denied for failing to meet one of these requirements (particularly the continuous 12-month requirement, because onset cannot be established before the date the individual arranged to undergo treatment). Accordingly, it is especially important that an explanation be given to the individual before a determination is made regarding failure to follow prescribed treatment, so that he or she will understand all the implications of continued failure to follow treatment.

Blindness: Title XVI

The principle of "failure" is generally applicable in title XVI statutory blindness cases. An individual who would otherwise be found blind, but who fails without justifiable cause to follow treatment which is prescribed by a treating source and which can be expected to restore vision to the extent that he or she would no longer be blind, cannot by virtue of such "failure" be found to be blind for title XVI purposes. As in regular "disability" cases, the issue of failure to follow prescribed treatment in title XVI blindness cases arises only when all of the following conditions exist:

1. The evidence establishes that the individual is blind; and
2. Treatment which is clearly expected to restore vision to the extent that the individual will no longer be blind has been prescribed by a treating source; and
3. The evidence of record discloses that there has been refusal to follow prescribed treatment.

When all of the above conditions are present, a favorable decision should be prepared and payments started pending resolution of the "failure" issue, since duration is not a factor. Development should then be initiated (at the hearing or AC levels, the case will be referred to the effectuating component) to obtain the information required to determine whether "failure" is justifiable. To protect the individual's right to "due process," benefits will not be denied until the claimant or beneficiary is informed that SSA intends to find "failure" and of the effects of such a determination.

In the event that the individual is found to be failing to follow prescribed treatment and such "failure" is not justifiable, blindness will be found to cease effective with the date of the adverse determination, with payments continuing for 2 months thereafter.

Eligibility for payments may be established in some cases based only on evidence furnished by an optometrist. While such evidence may indicate the probable need for treatment, it is not of itself sufficient to establish that treatment has been prescribed that will restore vision (for the purpose of determining "failure"), because an optometrist is not licensed to prescribe such treatment. Further, even though a purchased medical examination obtained from a physician skilled in diseases of the eye would satisfy the requirement of a licensed medical source, such evidence would not satisfy the requirement that the treatment be prescribed by the individual's treatment source. In either instance (i.e., where medical evidence of "failure" is not from the individual's treatment source, or where the only evidence is from an optometrist, regardless of whether or not he or she indicates a possible need for treatment), the cases will be referred to VR.

EFFECTIVE DATE: The PPS is effective with the date of the final regulations which reflect this policy. Those regulations were published in the *Federal Register* on August 20, 1980 (45 FR 55566).

CROSS-REFERENCES: Program Operations Manual System, sections DI 2207-2208.C.

TITLES II AND XVI: EVALUATION OF DRUG ADDICTION AND ALCOHOLISM

PURPOSE: To clarify the basic policy to be applied in the evaluation of title II and title XVI disability claims where drug addiction or alcoholism is present.

CITATIONS (AUTHORITY): Sections 216(i)(1)(A), 223(d)(1)(A), 223(d)(2)(A), 1611(e)(3)(A), 1611(e)(3)(B), 1614(a)(3)(A), 1614(a)(3)(B), and 1631(a)(2), of the Social Security Act; Regulations No. 4, Subpart P, sections 404.1505-404.1510, 404.1520-404.1522, 404.1525(e), 404.1545, 404.1563, 404.1512, 404.1513, and Appendix 1, Listing of Impairments, Part A, Subpart U, section 404.2001; Regulations No. 16, Subpart F, section 416.601; Subpart I, sections 416.905, 416.908, 416.910, 416.920-416.922, 416.945, 416.963, 416.912, 416.913, 416.935-416.939, Subpart Q, sections 416.1720, and 416.1725.

PERTINENT HISTORY: The Social Security Administration's policy in evaluating disability where drug addiction or alcoholism is present has been subject to some misinterpretation. Questions have arisen as to whether drug addiction or alcoholism in and of themselves can be considered disabling, whether confinement for treatment of drug addiction or alcoholism is to be taken into consideration in determining whether a severe impairment exists, and what factors must be considered in determining the severity or lack of severity of the impairment.

There has also been some misunderstanding regarding how the title XVI (Supplemental Security Income) provisions affect, if at all, the process of evaluating disability. The regulation requires that a disabled person who is medically determined to be a drug addict or alcoholic and whose drug addiction or alcoholism is a contributing factor to his or her disability undergo prescribed treatment if available and have a representative payee.

POLICY STATEMENT: The definition of disability is the same under title II and title XVI. Also, the principles underlying the adjudication of disability claims from drug addicts or alcoholics are the same as those underlying the adjudication of claims from other any individual. Any determination that an individual meets the definition of disability must be based on sufficiently detailed medical evidence describing the severity of the impairment and, when appropriate, on other information such as the individual's vocational history. The medical evidence must describe an impairment which results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. Furthermore, the impairment must be established by medical evidence consisting of symptoms, signs, and pertinent clinical and laboratory findings, not only by the individual's allegations or statement of symptoms. Finally, impairments must be of sufficient severity to meet or equal a listed impairment in Appendix 1 of Subpart P of Regulations No. 4 (incorporated by reference for title XVI in section 416.925) or, considering appropriate vocational factors, to prevent the individual from performing past relevant work or any other work.

Drug addicts or alcoholics cannot be considered "disabled" on the basis of that diagnosis alone; on the other hand, a diagnosis of drug addiction or alcoholism should not have an effect on a disability evaluation that is adverse to the applicant. Drug addicts and alcoholics are subject to all the ills that may affect any other applicant. Drug addiction and alcoholism are diagnostic terms; they do not denote impairment value or severity. It is necessary to evaluate the severity of the impairment which may be associated with, manifested by, result from, or coexist with these diagnoses.

It must be recognized also that the issue of whether the individual has lost the ability to control the use of drugs or alcohol affects the matter of diagnosis. The loss of ability to control these substances identifies the individual as a drug addict or alcoholic diagnostically, but does not provide a conclusive basis for evaluating the severity of the impairment.

Confinement in an institution or other facility, whether for treatment or otherwise, may occur for reasons other than the severity of the impairment. Although the circumstances concerning the confinement must be determined and considered, confinement alone does not establish that the impairment is severe. Also, confinement which is the treatment prescribed by an appropriate treating source does not establish the presence or severity of an impairment. The presence of an impairment and its severity is established on the basis of the symptoms, signs, and pertinent clinical and laboratory findings appropriate to that impairment. Similarly, release from an institution or any other facility does not establish that an impairment has improved, or that an impairment is not severe.

Ultimately, the decision will depend upon the severity of the impairment, as properly documented by the required medical findings, and, for appropriate cases, the limitation of function imposed on the applicant by the impairment in conjunction with applicable vocational factors. An individual may be a drug addict or an alcoholic and not be disabled if the evidence fails to show inability to engage in substantial gainful activity.

The basic medical evaluation criteria are found in the Listing of Impairments (Appendix 1 to Regulations No. 4, Subpart P, and incorporated by reference in section 416.925 of Regulations No. 16, Subpart I). The introduction to the mental impairment listing, section 12.00, provides a comprehensive summary of the basic evaluation principles to be applied to cases involving mental disorders, including those where drug addiction or alcoholism is present. Drug addiction and alcoholism are found under functional nonpsychotic disorders, listing 12.04. Section 12.04 was revised in 1974 for title XVI (Supplemental Security Income) cases and in 1975 for title II cases to clarify the evaluation concept to be applied in mental cases involving drug addicts or alcoholics. The former listing 12.04G3 (addictive dependence to drug or alcohol with irreversible organ damage) was deleted at that time because it was frequently misunderstood. By some, it was considered a bar to finding drug addicts or alcoholics disabled regardless of the true severity of the impairment or impairments present. Others would erroneously find a severity of impairment based solely on the diagnosis of drug addiction or alcoholism in the presence of any organ damage. The deletion of listing 12.04G3 did not liberalize or change the disability standards for drug addicts or alcoholics. (Cases involving organ damage are evaluated under the particular body system.) As in all disability cases, the impairment must be assessed in view of the individual's total medical condition and its effect on his or her ability to function.

Adequate information must be obtained to permit proper evaluation of the individual's impairment(s). It is very important that relevant medical evidence—including history, physical examination, and pertinent laboratory data—be secured from treatment sources. If sufficient evidence for a decision is not available from these sources, an additional medical examination is required. It may be necessary for this examination to be performed by an internist, neurologist, psychiatrist, or other medical specialist, depending on the type of impairment(s) in question and the evidence which is needed.

The medical evidence is then evaluated to determine whether the individual' s impairment, or impairments in combination, is of a level of severity and of expected duration to meet, or to be medically equivalent to, the Listing of Impairments. If any of these medical evaluation criteria are met or equaled, the individual is found to be disabled. If they are not, and the individual has a severe impairment, the impact of the impairment on his or her ability to work must be considered in terms of vocational factors such as age, education and prior work experience. Then, the decision as to disability is made.

Under both title II and title XVI, a claimant whose disability has been established must follow the treatment prescribed by a treating physician if the treatment could restore the ability to work. In addition, an individual whose disability has been established cannot refuse to accept vocational rehabilitation services without a good reason. Under title XVI, special conditions are required of individuals who are found disabled and for whom drug addiction or alcoholism is a contributing factor material to the finding of disability. These individuals are required (1) to undergo treatment appropriate to the condition of drug addiction or alcoholism at an approved institution or facility, when that treatment is available, and (2) to receive benefit payments through a representative payee. The chief purpose of the treatment and representative payee provisions for drug addicts and alcoholics under title XVI is to rehabilitate the individual to enable him or her to become a productive member of society and, thus, to remove the individual from the disability rolls.

Section 416.935 of the title XVI (Supplemental Security Income) regulations provide that an individual will be medically determined to be a drug addict or alcoholic only if he or she is under a disability (as defined in regulations section 416.905) and drug addiction or alcoholism is material to the finding of disability. The policy set forth in the regulations was developed following extensive consultations with other concerned Government agencies (e.g., the Alcohol, Drug Abuse and Mental Health Organizations, and the Special Action Office for Drug Abuse Prevention). A critical issue in applying the medically determined drug addiction or alcoholism provision under title XVI (i.e., undergoing appropriate, available treatment and receiving payments through a representative payee) is that the provisions are not applied until the adjudication of the claim results in a decision of disability. These special title XVI provisions only establish additional requirements after the individual is found disabled; they do not establish a different basis for evaluating disability for individuals who are drug addicts or alcoholics.

Where the definition of disability is met in a title XVI claim, and there is evidence of drug addiction or alcoholism, a determination must also be made as to whether the drug addiction or alcoholism was a factor material to the finding of disability for purposes of applying the treatment and representative payee provisions. In making this decision the key issue is whether the individual would continue to meet the definition of disability even if drug and/or alcohol use were to stop. If he or she would still meet the definition, drug addiction or alcoholism is not material to the finding of disability and the treatment and representative payee provisions do not apply. The drug addiction and alcoholism requirements are imposed only where (1) the individual's impairment(s) is found disabling and drug addiction and/or alcoholism is a contributing factor material to the determination of disability, and (2) the same impairment(s) would no longer be found disabling if the individual's drug addiction or alcoholism were eliminated as, for example, through rehabilitation treatment.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulation covering the basic policy in the subject area was effective (45 FR 55566).

CROSS-REFERENCES: Program Operations Manual System, Part 4, sections DI 2155-2155.35 and DI 00405.001ff.

TITLES II AND XVI: PAST RELEVANT WORK—THE PARTICULAR JOB OR THE OCCUPATION AS GENERALLY PERFORMED

PURPOSE: To clarify the policy in determining whether a claimant can perform his or her past relevant work, i.e., whether the claimant retains the residual functional capacity (RFC) to perform the physical and mental demands of the kind of work he or she has done in the past.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act, as amended; Regulations No. 4, sections 404.1520(e), 404.1545, 404.1561 and 404.1565(a); Regulations No. 16, sections 416.920(e), 416.945, 416.961 and 416.965(a).

PERTINENT HISTORY: The part of the law pertaining to past relevant work provides that as a part of the requirements for a finding of disability a claimant must have a medically determinable physical or mental impairment of such severity that he or she is not able to do his or her previous work. Sections 404.1520(e) and 416.920(e) of the regulations state as follows:

> "Your impairment must prevent you from doing past relevant work. If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment, we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. *If you can still do this kind of work*, we will find that you are not disabled." (Underscoring added.)

The regulations further state, in sections 404.1565(a) and 416.965(a), that work experience applies (is relevant) when it was done within the last 15 years, lasted long enough for the person to learn to do it and was substantial gainful activity.

A basic program principle is that a claimant's impairment must be the primary reason for his or her inability to engage in substantial gainful work. This reflects the intent of Congress that there be a clear distinction between disability benefits and unemployment benefits. Congress has also expressed the intent that disability determinations be carried out in as realistic a manner as possible.

Three possible tests for determining whether or not a claimant retains the capacity to perform his or her past relevant work are as follows:

1. Whether the claimant retains the capacity to perform a past relevant job based on a broad generic, occupational classification of that job, e.g., "delivery job," "packaging job," etc.

   Finding that a claimant has the capacity to do past relevant work on the basis of a generic occupational classification of the work is likely to be fallacious and unsupportable.

While "delivery jobs," or "packaging jobs," etc., may have a common characteristic, they often involve quite different functional demands and duties requiring varying abilities and job knowledge.

2. Whether the claimant retains the capacity to perform the particular functional demands and job duties peculiar to an individual job as he or she actually performed it.

   Under this test, where the evidence shows that a claimant retains the RFC to perform the functional demands and job duties of a particular past relevant job as he or she actually performed it, the claimant should be found to be "not disabled."

3. Whether the claimant retains the capacity to perform the functional demands and job duties of the job as ordinarily required by employers throughout the national economy. (The *Dictionary of Occupational Titles* (DOT) descriptions can be relied upon—for jobs that are listed in the DOT—to define the job as it is *usually* performed in the national economy.) It is understood that some individual jobs may require somewhat more or less exertion than the DOT description.

   A former job performed in by the claimant may have involved functional demands and job duties significantly in excess of those generally required for the job by other employers throughout the national economy. Under this test, if the claimant cannot perform the excessive functional demands and/or job duties actually required in the former job but can perform the functional demands and job duties as generally required by employers throughout the economy, the claimant should be found to be "not disabled."

POLICY STATEMENT: Under sections 404.1520(e) and 416.920(e) of the regulations, a claimant will be found to be "not disabled" when it is determined that he or she retains the RFC to perform:

1. The actual functional demands and job duties of a particular past relevant job; *or*
2. The functional demands and job duties of the occupation as generally required by employers throughout the national economy.

EFFECTIVE DATE: Final regulations covering this policy were published in the *Federal Register* on August 20, 1980 (45 FR 55566).

FURTHER INFORMATION: A properly completed SSA-3369-F6, Vocational Report, may be sufficient to furnish information about past work. There may be cases involving significant variations between a claimant's description and the description shown in the DOT. In some instances, an apparent variation may result from an incomplete or inaccurate description of past work. Employer contact or further contact with the claimant, may be necessary to resolve such a conflict. Also composite jobs have significant elements of two or more occupations and, as such, have no counterpart in the DOT. Such situations will be evaluated according to the particular facts of each individual case. For those instances where available documentation and vocational resource material are not sufficient to determine how a particular job is usually performed, it may be necessary to utilize the services of a vocational specialist or vocational expert.

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 2041, 2068, 2093, 2105D, 2380D, and 2383A.

TITLES II AND XVI: A DISABILITY CLAIMANT'S CAPACITY TO DO PAST RELEVANT WORK, IN GENERAL

PURPOSE: To state the policy and explain the procedures for determining a disability claimant's capacity to do past relevant work (PRW) as set forth in the regulations, and to clarify the provisions so that they will be consistently applied.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1505(a), 404.1520(e), 404.1560, 404.1561, 404.1562, and 404.1565; and Regulations No. 16, Subpart I, sections 416.905(a), 416.920(e), 416.960, 416.961, 416.962, and 416.965.

INTRODUCTION: To be found disabled under the law, an individual (except for a title II widow, widower, or surviving divorced spouse, or a title XVI child younger than age 18) must have a medically determinable physical or mental impairment(s) of such severity that he or she is not only unable to do his or her previous work but cannot, considering his or her age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy. The regulations provide a sequential evaluation process for determining disability. In the fourth step of this process, consideration is given to the individual's capacity to perform PRW. Sections 404.1520(e) and 416.920(e) of the regulations state as follows:

> "*Your impairment must prevent you from doing past relevant work.* If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment, we then review your residual functional capacity [RFC] and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled."

POLICY STATEMENT:

The Relevance of Past Work

The term "work experience" means skills and abilities acquired through work previously performed by the individual which indicates the type of work the individual may be expected to perform. Work for which the individual has demonstrated a capability is the best indicator of the kind of work that the individual can be expected to do. Sections 404.1565(a) and 416.965(a) of the regulations state as follows: "We consider that your work experience applies [i.e., is relevant] when it was done within the last 15 years, lasted long enough for you to learn to do it, and was substantial gainful activity [SGA]."

Except for the purpose of determining whether the disability criteria of sections 404.1562 and 416.962 of the regulations are met, work performed 15 years or more prior to the time of adjudication of the claim (or 15 years or more prior to the date the title II disability insured status requirement was last met, if earlier) is ordinarily not considered relevant.

An individual who has worked only sporadically or for brief periods of time during the 15-year period, may be considered to have no relevant work experience.

Capacity to do past work may be indicative of the capacity to engage in SGA when that work experience constituted SGA and has current relevance considering duration and recency.

1. SGA

   The adjudicative criteria for determining whether a person has done "substantial" and "gainful" work activity are explained in sections 404.1571-404.1575 and 416.971-416.975 of the regulations.

2. Duration

   Duration refers to the length of time during which the person gained job experience. It should have been sufficient for the worker to have learned the techniques, acquired information, and developed the facility needed for average performance in the job situation. The length of time this would take depends on the nature and complexity of the work.

3. Recency

   Recency refers to the time which has elapsed since the work was performed. A gradual change occurs in most jobs in our national economy so that after 15 years it is no longer realistic to expect that skills (or proficiencies) and abilities acquired in these jobs continue to apply. The 15-year guide is intended to insure that remote work experience which could not reasonably be expected to be of current relevance is not applied.

While the regulations provide that a claimant/beneficiary's work experience is usually relevant when the work "was done within the last 15 years," in some cases worked performed prior to the 15-year period may be considered as relevant when a continuity of skills, knowledge, and processes can be established between such work and the individual's more recent occupations.

The following subsections describe how the relevant 15-year period will be determined.

1. When deciding whether a claimant is disabled under title II or title XVI, the 15-year period is generally the 15 years prior to the time of adjudication at the initial, reconsideration or higher appellate level.

2. In those title II cases in which the claimant's disability insured status was last met prior to adjudication, the work performed for the 15-year period preceding the date the title II disability insured status requirement was last met would generally be considered relevant, since the claimant's capacity for SGA as of that date represents a critical disability issue.
3. When deciding whether a title II or a title XVI beneficiary *continues* to be disabled, relevant past work is work he or she performed in the 15-year period prior to adjudication of the issue of continuing disability.

What the Claimant Can Now Do Physically and Mentally—RFC

Evaluation under sections 404.1520(e) and 416.920(e) of the regulations requires careful consideration of the interaction of the limiting effects of the person's impairment(s) and the physical and mental demands of his or her PRW to determine whether the individual can still do that work.

Since the severity of the impairment(s) must be the primary basis for a finding of disability, evaluation begins with a determination of the claimant's functional limitations and capacities to sit, stand, walk, lift, carry, etc. (See SSR 82-51 (PPS-85: Guidelines for Residual Functional Capacity Assessment in Musculoskeletal and Cardiovascular Impairments).)

Comparing RFC with the Physical and Mental Demands of Past Relevant Occupations

The RFC to meet the physical and mental demands of jobs a claimant has performed in the past (either the specific job a claimant performed or the same kind of work as it is customarily performed throughout the economy) is generally a sufficient basis for a finding of "not disabled." Past work experience must be considered carefully to assure that the available facts support a conclusion regarding the claimant's ability or inability to perform the functional activities required in this work. (See SSR 82-61 (PPS-72: Past Relevant Work—The Particular Past Job or the Occupation as Generally Performed) and SSR 82-40: (PPS-69: The Vocational Relevance of Past Work Performed in a Foreign Country).)

The claimant is the primary source for vocational documentation, and statements by the claimant regarding past work are generally sufficient for determining the skill level, exertional demands and nonexertional demands of such work. Determination of the claimant's ability to do PRW requires a careful appraisal of (1) the individual's statements as to which past work requirements can no longer be met and the reason(s) for his or her inability to meet those requirements; (2) medical evidence establishing how the impairment limits ability to meet the physical and mental requirements of the work; and (3) in some cases, supplementary or corroborative information from other sources such as employers, the *Dictionary of Occupational Titles*, etc., on the requirements of the work as generally performed in the economy.

The decision as to whether the claimant retains the functional capacity to perform past work which has current relevance has far-reaching implications and must be developed and explained fully in the disability decision. Since this is an important and, in some instances, a controlling issue, every effort must be made to secure evidence that resolves the issue as clearly and explicitly as circumstances permit.

Sufficient documentation will be obtained to support the decision. Any case requiring consideration of PRW will contain enough information on past work to permit a decision as to the individual's ability to return to such past work (or to do other work).

Adequate documentation of past work includes factual information about those work demands which have a bearing on the medically established limitations. Detailed information about strength, endurance, manipulative ability, mental demands and other job requirements must be obtained as appropriate. This information will be derived from a detailed description of the work obtained from the claimant, employer, or other informed source. Information concerning job titles, dates work was performed, rate of compensation, tools and machines used, knowledge required, the extent of supervision and independent judgment required, and a description of tasks and responsibilities will permit a judgment as to the skill level and the current relevance of the individual's work experience. In addition, for a claim involving a mental/emotional impairment, care must be taken to obtain a precise description of the particular job duties which are likely to produce tension and anxiety, e.g., speed, precision, complexity of tasks, independent judgments, working with other people, etc., in order to determine if the claimant's mental impairment is compatible with the performance of such work. Persons with physical impairments (e.g., cardiovascular or gastrointestinal disorders) may have performed stressful tasks. This may also require a decision as to whether the impairment is compatible with the performance of such work. If more than one job was performed during the 15-year period, separate descriptions of each job will be secured.

The Disability Determination or Decision Where a Claimant or Beneficiary Can Meet the Physical and Mental Demands of a Past Relevant Occupation

The rationale for a disability decision must be written so that a clear picture of the case can be obtained. The rationale must follow an orderly pattern and show clearly how specific evidence leads to a conclusion.

The file will contain all the pertinent information with respect to the medical aspects of the case as well as the nonmedical facts.

The explanation of the decision must describe the weight attributed to the pertinent medical and nonmedical factors in the case and reconcile any significant inconsistencies. Reasonable inferences may be drawn, but presumptions, speculations and suppositions must not be used.

A decision that an individual is not disabled, if based on sections 404.1520(e) and 416.920(e) of the regulations, must contain adequate rationale and findings dealing with all of the first four steps in the sequential evaluation process.

In finding that an individual has the capacity to perform a past relevant job, the determination or decision must contain among the findings the following specific findings of fact:

1. A finding of fact as to the individual's RFC.
2. A finding of fact as to the physical and mental demands of the past job/occupation.
3. A finding of fact that the individual's RFC would permit a return to his or her past job or occupation.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 2041, 2382, 2383, 2383.1, 2387, 2389, and 3027.

TITLES II AND XVI: MEDICAL-VOCATIONAL PROFILES SHOWING AN INABILITY TO MAKE AN ADJUSTMENT TO OTHER WORK

PURPOSE: To clarify that there are two "medical-vocational profiles" which show an inability to make a vocational adjustment to other work (or any work) and which must be considered before a disability decisionmaker refers to Appendix 2 of Subpart P of Regulations No. 4 to determine whether a claimant can do work which exists in significant numbers in the national economy, considering the interaction of the claimant's residual functional capacity (RFC), age, education, and work experience. The characteristics of these two profiles are: (1) marginal education and long work experience limited to arduous unskilled physical labor and (2) advanced age, limited education and no work experience.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1505(a), 404.1520(f), 404.1521, 404.1545, 404.1560, 404.1561, 404.1562, 404.1563(d), 404.1564, 404.1565, and 404.1568; Appendix 2 of Subpart P, Regulations No. 4, sections 203.00(b) and (c); and Regulations No. 16, Subpart I, sections 416.905(a), 416.920(f), 416.921, 416.945, 416.960, 416.961, 416.962, 416.963(d), 416.964, 416.965 and 416.968.

INTRODUCTION: The law provides that, in order to be found disabled, an individual (except for a title II widow, widower, or surviving divorced spouse or a title XVI child younger than age 18 or a "statutorily blind" individual) must have a medically determinable physical or mental impairment(s) of such severity that he or she is not only unable to do previous work but cannot, considering his or her age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy. Sections 404.1520/416.920 of the regulations provide a sequential evaluation process whereby current work activity, severity and duration of the impairment(s), ability to do past work, and vocational factors are considered in that order. In the fifth and last step of the sequential evaluation process, consideration is given to the impaired individual's capability to perform other work differing from that of his or her past relevant work experience (or, in the case of a person without work experience, his or her capability to begin to work). At this step, we consider what the person can do functionally and the vocational factors of his or her age, education, and work experience.

Work Experience Limited to Arduous Unskilled Physical Labor

Regulations issued in 1957 to implement the title II disability program provided for the consideration of vocational factors in addition to the primary consideration given to the severity of the worker's impairment.

In 1960, section 404.1502(c) was added to the regulations as the first specific directive for a finding of disability based on both medical and vocational factors. That section described an individual whose vocational limitations are so restrictive that the existence of an impairment which prevents the individual from doing his or her usual level of work would ordinarily justify a finding of disability. The provisions of former section 404.1502(c) are now reflected in sections 404.1562/416.962 of the regulations. These sections address the claimant who has only a marginal education and work experience limited to 35 years or more of arduous unskilled physical labor. Rule 203.01 in Table No. 3 of Appendix 2 somewhat approximates the criteria in those sections. However, should rule 203.01 be referred to before sections 404.1562/416.962, an individual younger than age 60 with a background of 35 years or more in unskilled arduous physical labor might be overlooked.

No Work Experience

Under title II, a person must have a significant and recent attachment to the work force to acquire disability insured status.

Disability benefits under title XVI were first payable in 1974. Under the title XVI program, financial need—low income and resources—is an eligibility criterion rather than disability insured status. However, the disability evaluation standards are essentially the same for both titles II and XVI. Since a large number of title XVI claimants have little or no work history, the question arose as to how much adjudicative weight should be given to the absence of work experience. The lack of work experience is a vocationally adverse factor in that a person who has not been in the labor market has not developed any basic knowledge of work products or services, the ability to relate and communicate to supervisors and coworkers, the work habits of scheduling time, etc. Recognizing that as a person grows older the ability to compensate for the lack of work experience diminishes, the Social Security Administration (SSA) established a policy in 1975 which provided that, up to a point, all other factors being equal, claimants without work experience and those who have performed only unskilled work would be treated the same. That point is advanced age. The policy decision, in effect, directs a finding of disability where a person has a severe impairment of any nature, is of advanced age, has only the limited educational competence required for unskilled work, and has no work experience at all or no recent and relevant work experience.

Rules 203.02 and 203.10 in Table No. 3 of Appendix 2 reflect the policy decision in July 1975 with respect to persons who have a severe exertional impairment which limits them to the medium level of work exertion. However, should only rules 203.02 and 203.10 be considered, a person with a severe nonexertional impairment who is of advanced age, has a limited education, and has no recent and relevant work experience might not be found to be disabled.

POLICY STATEMENT: When an adjudicator has reached the last step of the sequential evaluation process—sections 404.1520(f)/416.920(f) of the regulations—he or she must consider two medical-vocational profiles which direct decisions of disability before considering the numbered rules in Appendix 2 of the regulations.

1. *Work Experience Limited to Arduous Unskilled Physical Labor*

   Sections 404.1562/416.962 of the regulations describe a set of functional and vocational limitations which present such an unfavorable vocational profile that an inability to make a vocational adjustment to other work may be inferred if the person meets these requirements and is not engaging in substantial gainful activity. To meet the criteria of these sections, the person must have a marginal education and long work experience (i.e., 35 years or more) limited to the performance of arduous unskilled physical labor which can no longer be performed because of a severe impairment(s). Careful examination of the evidence, including a description of all jobs the individual has held (with sufficient details about job content to show any skills involved and the level of physical exertion required) is necessary to establish whether the individual meets each criterion.

   The adjudicator must make a complete assessment of all the pertinent elements in the regulations. While there is room for judgment in determining whether the criteria of sections 404.1562/416.962 are met, judgment cannot be used to substitute for basic documentation, to broaden the intent of the regulations, or to disregard specified criteria. Rule 203.01 of Appendix 2 contains criteria which somewhat approximate those in sections 404.1562/416.962. When neither set of criteria is met, a substantive decision regarding disability requires an assessment of the person's capacity for other work on the basis of the principles and definitions in the regulations and rules other than 203.01 in Appendix 2.

Severity of Impairment

For the purpose of evaluation under sections 404.1562/416.962 of the regulations, an impairment must be severe and prevent the performance of arduous physical labor. It is necessary to assess the person's RFC and to relate it to the physical and mental demands of his or her arduous work background.

History of Arduous Unskilled Work

The individual's work history must have the following characteristics:

a. Duration of Work Experience 35 Years or More

This criterion assures that the person has a long-term commitment to work which is arduous and unskilled.

b. Arduous Work

Arduous work is primarily physical work requiring a high level of strength or endurance. No specific physical action or exertional level denotes arduous work. While arduous work will usually entail physical demands that are classified as heavy, the work need not be described as heavy to be considered arduous. For example, work involving lighter objects may be arduous if it demands a great deal of stamina or activity such as repetitive bending and lifting at a very fast pace. Thus, there is room for judgment in deciding whether this criterion is met.

c. Unskilled Work

Unskilled work consists of simple duties which require little or no judgment and may be learned in a short period of time (see sections 404.1568(a)/416.968(a) of the regulations for further discussion). The judgment that work is unskilled must be based on facts which describe fully the nature and extent of vocational competences necessary to the performance of the job duties.

Employment in semiskilled or skilled work generally would rule out the application of sections 404.1562/416.962 of the regulations. Isolated, brief, or remote periods of experience in semiskilled or skilled work, however, would not preclude the applicability of these regulations when such experience did not result in skills which enhance the person's present ability to do lighter work. Also, periods of semiskilled or skilled work may come within the provisions of these regulations if it is clear that the skill acquired is not readily transferable to lighter work and makes no meaningful contribution to the person's ability to do any work within his or her present functional capacity. (See examples in sections 404.1562/416.962.) When the transferability of the skill may be subject to question, the case should be evaluated under the provisions of sections 404.1568(d)/416.968(d).

Marginal Education

Marginal education (sections 404.1564(b)(2)/416.964(b)(2) of the regulations) indicates that the person may not have attained a level of development in reasoning, arithmetic, and language which would suggest a vocational potential for more than unskilled work. Generally, an individual is considered to have a marginal education if he or she has no more than a sixth grade elementary school education. However, the level of formal education is not conclusive of a person's vocational competence. The responsibilities and tasks of past employment may demonstrate a higher level of competence than that indicated by his or her formal schooling. Conversely, a person may have attended school beyond the sixth grade, but other evidence may establish capability for reasoning, arthimetic, and language which does not, in fact, exceed the "marginal" criterion.

(Where an individual with this profile can perform arduous unskilled physical labor, see SSR 82-62 (PPS-80: A Disability Claimant's Capacity to Do Past Relevant Work, in General).)

2. *Special "No Work Experience" Cases*

An SSA policy decision of July 7, 1975, provided that, up to the point of advanced age, persons without work experience and those who have performed only unskilled work will be given the same consideration. Recognizing that advanced age (55 or older) is a critical point for a vocational adjustment in that a person would have much difficulty in learning and doing activities not previously performed, SSA decided that a special policy should apply to disability claimants and beneficiaries who are of advanced age and have no recent and relevant work experience.

Generally, individuals are considered as having no recent and relevant work experience when they have either performed no work activity within the 15-year period prior to the point at which the claim is being considered for adjudication, or the work activity performed within this 15-year period does not (on the basis of job content, recency, or duration) enhance present work capability.

All such cases requiring vocational consideration must be decided on the basis of whether the individual's RFC, age, education, and lack of work experience are compatible with an adjustment to competitive remunerative work. Although the absence of relevant work experience represents an adverse vocational consideration, the adjudicative weight to be ascribed to this factor must be viewed in the context of the substantial numbers of unskilled jobs in the national economy which involve only simple job duties that can be learned in a short period of time and require no previous qualifying work experience.

Therefore, the absence of work experience can be evaluated only in the context of the range of work the individual can do functionally and of the other vocational factors of age, education and training. The following adjudicative guidelines provide a perspective for evaluating the interaction of the functional and vocational variables in cases involving individuals without work experience:

Generally, the RFC to perform a wide range of light work reprersents sufficient capacity to engage in substantial work for the individual who is not of advanced age and can communicate, read, and write on a marginal educational level.

Generally, where an individual of advanced age with no relevant work experience has a limited education or less, a finding of an inability to make a vocational adjustment to substantial work will be made, provided his or her impairment(s) is severe, i.e., significantly limits his or her physical or mental capacity to perform basic work-related functions.

In the cases involving individuals of advanced age, the only medical issue is the existence of a severe medically determinable impairment. The only vocational issues are advanced age, limited education or less, and absence of relevant work experience. With affirmative findings of fact, the conclusion would generally follow that the claimant or beneficiary is under a disability. If all the criteria of this medical-vocational profile are not met, the case must be decided on the basis of the principles and definitions in the regulations, giving consideration to the rules for specific case situations in Appendix 2.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 2041C, 2381, and 2387B.6.

(Previously Published as PPS-86) **SSR 82-64**

TITLES II AND XVI: THE OBLIGATION OF THE SOCIAL SECURITY ADMINISTRATION (SSA) TO INVESTIGATE CONTINUANCE OF DISABILITY AND EVALUATION GUIDES FOR DETERMINING WHETHER DISABILITY CONTINUES

PURPOSE: To state the obligations of SSA to investigate continuance of disability and provide the standards and evaluation guides for determining whether disability continues.

CITATIONS (AUTHORITY): Sections 216(i), 223(d), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1530, 404.1589, 404.1590, 404.1593, and 404.1598; and Regulations No. 16, Subpart I, sections 416.930, 416.989, 416.990, 416.993, and 416.998.

INTRODUCTION: This Program Policy Statement (PPS) states the reason for conducting continuing disability investigations and contains an explanation of several policies for evaluating disability claims which are to be used as guides in deciding whether an individual is currently disabled. These policies include finding that disability or blindness has stopped if new evidence shows the person is not disabled or blind as defined in the law, determining when a person becomes disabled by another impairment, evaluating residual functional capacity and vocational background, securing consultative examinations to resolve medical issues, and evaluating some special considerations in continuing disability cases. These policies are applicable to all determinations.

POLICY STATEMENT:

The Obligation to Investigate Continuance of Disability

Disability ceases when the physical or mental impairment together with the vocational profile (i.e., his or her age, education, work experience, etc.), where appropriate, does not prevent the individual from engaging in substantial gainful activity (SGA) or, subject to the trial work period (TWP) provisions, the individual demonstrates, by working, the ability to engage in SGA (except in certain title II cases based on statutory blindness).

SSA has an obligation to terminate benefits based on disability and freeze periods when an individual is not disabled. The primary purpose of a continuing disability investigation (CDI) is to obtain complete and current information about the disabled individual's physical and/or mental condition and any work activity. The information is required so that an evaluator may determine whether the individual is still under a disability.

The 1980 disability amendments (P.L. 96-265) provide certain work incentive benefits to persons who complete 9 months of trial work and whose disability ceases because of their activity. To qualify for the work incentive benefits, the person must continue to have a disabling impairment. CDI's are conducted in these cases if there is reason to question whether the impairment continues to be disabling.

Evaluation Guides for Determining Whether Disability Continues

The standards and the evaluation guidelines that apply in determining initial disability also apply in determining whether disability continues. The question to be resolved is whether the individual is currently disabled. The fact that the individual is currently receiving benefits on the basis of disability does not shift the burden of establishing that disability is continuing from the claimant to SSA. All evidence secured in connection with the original determination is in the folder for consideration. However, the determination or decision as to whether or not disability continues is not controlled by any prior determination or decision which established that the individual was disabled.

In determining whether the individual is currently disabled, current medical evidence will be obtained. It is not essential that the evidence indicate a change in the individual's impairment. Thus, it is possible current evidence will warrant a cessation of disability even where such evidence is essentially similar to the evidence of record when disability was originally established or when a prior CDI was conducted. This is true regardless of the administrative or judicial level at which disability was originally established or previously continued. Also, the fact that disability is ceased as a result of a CDI because the individual is not currently disabled would not ordinarily raise a question regarding the correctness of any prior determination or decision which found that the individual was disabled.

In determining whether the individual is currently disabled, the original impairments and any new conditions will be considered. If a new, severe impairment begins in or before the month in which the last impairment ceases to be disabling (i.e., the month of cessation) disability is continued until the individual has the capacity to engage in SGA. The new impairment need not be expected to last 12 months or result in death, but it must be severe enough to prevent the person from performing SGA. If the individual again becomes disabled after the month in which the last impairment ceases to be disabling, there is a break in the continuity of disability. This break requires a cessation of the last disability and independent consideration of any new impairment for a new disability, even though the new impairment may begin before the month of termination of the last period of disability. Severity and duration requirements must be met to establish a new disability.

If an individual's impairment might reasonably have been expected to improve (i.e., a medical reexamination diary was established), a subsequent return to work before the month of the scheduled medical reexamination is considered as a possible indication of medical recovery.

Where an individual's return to work coincided with an established medical reexamination diary, SSA may first learn of the individual's return to work through the individual's responses at the time of the continuing disability interview. SSA must carefully consider the development already undertaken, if any, to determine whether further medical documentation is needed and, if so, the type and extent necessary for a sound determination of continuance or cessation.

When an individual has been so severely impaired that an allowance was justified, some residual impairment may remain even after maximum treatment. The continuing disability evaluation process requires a determination as to whether any residual impairment precludes the individual from engaging in SGA.

When the question of continuing disability cannot be resolved on medical consideration alone, and it is necessary to consider vocational factors, and the individual is unable to return to past relevant work, evaluation of the claimant's ability to make an adjustment to other work will include consideration of skills acquired through vocational rehabilitation or other training. A new evaluation of the individual's present capacity to engage in SGA will be required in these cases.

SSA must evaluate the evidence with care before preparing a determination (either continuance or cessation) to assure that the total evidence accurately portrays the individual's current condition. When the medical and vocational evidence of record covering the original impairment and any new impairment establishes that the individual's condition together with the vocational profile, where appropriate, precludes SGA, in the absence of demonstrated SGA, a continuance is warranted. If, however, the evidence demonstrates that the individual's condition together with the vocational profile, where appropriate, does not preclude SGA, a cessation is appropriate. If information furnished by the individual concerning the current medical condition is consistent with the statements from the treating physician which are supported by clinical and laboratory findings, and there is no reason to believe that the indivdual's condition has changed, a determination as to the continuance or cessation of disability will be made without further development. In all cases in which the evidence of record is unavailable, inadequate, equivocal or inconclusive, a consultative examination will be obtained to resolve medical issues.

In disabled widow/widower cases, a finding of medical cessation is appropriate when the medical evidence shows the impairment does not meet or equal the Listing. In title XVI childhood cases, a finding of medical cessation is appropriate when the medical evidence shows the impairment does not meet or equal the childhood impairment listings in part B of the Listing of Impairments or the Part A listings where the childhood listings are not appropriate.

Special Evaluation Considerations

The following considerations assume particular importance in evaluating continuing disability cases:

1. Temporary Improvement

Improvement that is only temporary does not warrant a finding
the individual does not have a disabling impairment. The prob
duration of improvement and the prognosis should be carefully
sidered, particularly if the disease is characterized by periods o
mission followed by relapse. All factors must be considered befo
is concluded that improvement is more than temporary.

2. Examination Reflecting Result of Rest

Conditions which become comparatively symptom-free after
longed rest must be given careful consideration. Only where it
reasonably be expected that the capacity for SGA can be maintai
under ordinary conditions of life in work setting of the type for wh
the individual is qualified may a finding of cessation be made.

3. Medical Regimen

Generally, when an individual is hospitalized or a treating physic
markedly restricts an individual's activities, the signs, sympto
and laboratory findings will establish that a severe impairment ex
which continues to prevent the individual from engaging in any S
Hospitalization, prescribed therapy which prevents work, or
judgment by the treating source that the individual should not w
are not, however, in themselves, sufficient evidence to suppo
finding of continuance.

In making an independent judgment as to an individual's abilit
engage in SGA, the evidence provided by the individual's treat
physician must be considered. Careful consideration must alw
be given to the possibility that the treating physician has additio
medical information not reflected in the file which might suppo
finding of continuance. If, however, full development has b
undertaken and the evidence does not support a finding of disabi
under existing policies and regulations, a finding of cessation is
propriate.

4. Recommended Treatment Not Followed

In those cases where the previously recommended treatment has
been followed, all pertinent aspects, particularly with respect
why the recommended treatment has not been carried out, sho
be developed. Where the evidence establishes the individual's un
tified failure to follow prescribed treatment which could be
pected to restore the capacity for SGA, a finding of cessation sho
be made (see SSR 82-59 (PPS-78: Failure to Follow Prescribed Tr
ment).)

5. Nonrollback Conversion Cases

Where the individual was a supplemental security income gra
fatheree and is receiving SSI benefits based on disability, disabi
will be ceased when the individual's impairment as shown by curr
medical or other evidence does not meet the criteria of the appro
ate State plan or the Federal criteria (SSR 82-10c).

EFFECTIVE DATE: The policies covered by this PPS have been in effect for many years except for the policy on work incentives. This policy became effective December 1, 1980, as specified by the Social Security Disability Amendments of 1980.

CROSS-REFERENCE: Program Operations Manual System Part 4, Chapter II.

TITLES II AND XVI: THE DEVELOPMENT OF MEDICAL EVIDENCE IN A CONTINUING DISABILITY INVESTIGATION

PURPOSE: To state the policy for developing medical evidence in a continuing disability investigation (CDI).

CITATIONS (AUTHORITY): Sections 216(i), 223(d), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1513 and 404.1517; and Regulations No. 16, Subpart I, sections 416.913 and 416.917.

INTRODUCTION: This Program Policy Statement states the need to update the medical evidence at the time of a CDI to determine the current status of the beneficiary's impairment and indicates possible sources of this information.

POLICY STATEMENT:

Development of Medical Evidence

The development of medical evidence and the evidentiary requirements that apply in determining initial disability also apply in determining whether disability continues. However, the development of medical evidence in connection with a CDI is basically an updating process.

The medical evidence for determining continuing disability should consist of evidence which is sufficiently detailed as to signs, symptoms, and laboratory findings to enable a sound judgment to be made by an independent reviewer as to the individual's current condition. Detail is especially needed when the evidence indicates cessation of disability but the individual alleges inability to return to work due to the impairment or the treating physician has restricted work activity.

Medical Evidence of Record

If the individual has a current treatment source that source will always be requested to furnish reports of the most recent examination describing the individual's current medical condition. Depending upon the individual's clinical history, it may be necessary to develop the severity and duration of an impairment over an extended period of time. Some impairments, such as mental disorders, may have periods of exacerbation and remission which require the development of medical evidence earlier than one year before the date the CDI was initiated. However, in *all* cases, the Disability Determination Service (DDS) is required to make every effort to obtain all medical evidence of record (MER) from the treating physician and other medical sources that have treated the beneficiary within the past 12 months. The medical evidence should contain sufficient signs, symptoms, and laboratory findings to permit independent judgment for a sound determination of continuance or cessation.

Occasionally, the evidence from the treating source may not be sufficient to resolve the question of continuing disability. Nonetheless, the presence in file of reports from the individual's medical sources will better ensure that no pertinent evidence has been overlooked and thus ensure the soundest possible basis for making a disability determination. DDS efforts to obtain MER will *always* be documented.

Conflicts Between the Individual and the Medical Source

Ordinarily, the treating physician will tell the individual when his or her current medical condition permits a return to work. If, however, the individual states that the physician advised against return to work or the individual feels unable to work because of the impairment, but the medical evidence received from the treating physician indicates that the beneficiary is not disabled, the conflict must be resolved. If the treating physician's position is supported by conclusive objective medical evidence, a consultative examination is not required. However, if the conflict raises a substantive medical question and the treating physician's position is not fully documented as to signs, symptoms, and laboratory findings, a consultative examination by an independent medical source will be arranged before a determination is made.

Consultative Examinations

In addition to the resolution of conflict situations, a consultative examination will be obtained when evidence of record concerning the individual's condition is not available, is equivocal, or is not sufficiently detailed in terms of signs, symptoms, and laboratory findings to enable a sound independent judgment to be made.

Documentation

An unsigned report may be used to establish a favorable determination and a continuance may be processed pending confirmation by a signed report. However, medical evidence used to establish that the individual is not disabled must be in writing and signed by the source of the information.

The source will be properly identified. An exception can be made when a signed, written report was previously received during the current investigation and it is necessary only to confirm or clarify some detail by telephone. In this situation, a report of telephone conversation is sufficient.

Vocational Rehabilitation Agency

When an individual is known to a State Vocational Rehabilitation (VR) Agency at the time of the continuing disability investigation, the agency will be contacted for a full report about the individual including medical reports relating to the individual's current medical status and other data pertinent to a determination. If data previously obtained from the agency (e.g., in connection with the initial adjudication) indicated that the case was closed and the individual states that the case has not been reopened, a further contact with VR will not be made. Evidence secured from the treating source and evidence available through the VR agency may be sufficient to permit a sound determination as to whether disability continues.

In no instance will a clear-cut cessation (i.e., cessation without current medical development on the basis medical recovery is indicated by return to full-time work without medical restrictions) be made where VR services are continuing since participation in VR constitutes "evidence to the contrary." Medical recovery may normally be found when current medical evidence establishes a present capacity for engaging in substantial gainful activity. When the medical evidence establishes such capacity, cessation will be found despite the fact that the individual may be an active participant in a State-sponsored vocational rehabilitation program.

> Example:
>
> Claimant was determined to be disabled because of multiple fractures and complications which indicated the disability condition would meet the 12-month duration requirement. When the medical reexamination diary came due, the CDI disclosed that the individual was enrolled in a 2-year bookkeeping course under a State-sponsored VR program. The State agency adjudicator obtained evidence from the VR, which stated that one year of schooling remains. The Social Security Administration then obtained current medical evidence which clearly established medical recovery. Therefore, a determination of cessation was made.

Drug Addiction and Alcoholism

Any drug addiction and alcoholism (DA and A) case in which a CDI is initiated will be developed under the basic guides which apply to any other CDI. Specifically, documentation should include the following: (1) The Report of Continuing Disability Interview; and (2) contact with the current treating sources, including the DA and A treatment facility. Documentation will be obtained for individuals who are currently in a treatment program (e.g., methadone maintenance, therapeutic treatment facility, etc.) as well as for those who have completed treatment or are otherwise reported out of treatment.

In conversion cases involving drug addicts or alcoholics, when the State welfare agency medical records and evidence used in making the original disaility determinations are unavailable, the issue of whether an individual is presently disabled on the basis of current medical and nonmedical evidence will be resolved.

Contact with the treatment facility will elicit the following information: (1) overall current manifestations of the drug addiction or alcoholism. (e.g., inability to relate to others, specific restrictions of daily activities); (2) an assessment of the present course of treatment and the need for continued treatment as well as the prognosis with or without continued treatment; and (3) a statement of functional ability and the reasons for any continuing loss of functional ability.

Note: Individuals who have been participating in a methadone maintenance program (or any other DA and A treatment program) and who continue to participate in such a program do not, simply by virtue of participating in such treatment, necessarily continue to meet the disability criteria under either Federal or State plan criteria. Evaluation of continuing disability must take into consideration whether the individual is well maintained on such treatment and has the current ability to function.

The need to order a consultative examination will depend on the information received from the recipient and the evidence obtained from the treating sources. When the evidence is equivocal or does not provide a sound basis for evaluation, a consultative examination will be obtained. (See SSR 82-60 (PPS-83: Evaluation of Drug Addiction and Alcoholism).)

EFFECTIVE DATE: The policies covered by this Program Policy Statement have been in effect for many years except for the 12-month requirement for obtaining medical evidence of record. This 12-month requirement became effective in May 1982.

CROSS-REFERENCE: Program Operations Manual System Part 4, Chapter II.

TITLES II AND XVI: ESTABLISHING THE CESSATION DATE IN A CONTINUING DISABILITY CASE

PURPOSE: To state the policy for establishing the date of a medical cessation or a cessation based on work activity and for determining when a retroactive cessation may apply as a result of a continuing disability investigation (CDI).

CITATIONS (AUTHORITY): Sections 216(i), 223(d), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.987-404.995, 404.1530, 404.1579, 404.1586, 404.1588, 404.1591, 404.1594; and Regulations No. 16, Subpart I, sections 416.930, 416.986, 416.988, 416.991, 416.994, and 416.1487-416.1494.

INTRODUCTION: This Program Policy Statement states the general rule for establishing a current cessation date in most medical cessation cases and lists the types of cases in which a retroactive cessation date may apply. These include cases involving reports of earlier medical cessation, a return to work in a medically diaried case, and work activity that demonstrates an ability to do substantial gainful activity (SGA). In addition, a retroactive cessation date may be established where the beneficiary fails to cooperate or fails to follow prescribed treatment, or where his or her whereabouts are unknown. This Program Policy Statement also explains how the establishment of a retroactive date of cessation may be limited by the rules of administrative finality.

POLICY STATEMENT:

Establishing the Date of a Medical Cessation

Historically, whenever the Social Security Administration (SSA) found that the beneficiary's impairment was not of sufficient severity to prevent SGA and medical and vocational evidence indicated that the disability or blindness had ended some time in the past, SSA would establish a retroactive cessation date. However, it was often difficult to accurately establish a past date on which disability or blindness ended. Because of the nature of the evidence relied on to establish a date of a medical cessation, a determination of retroactive cessation could be (and often was) made even though the beneficiary may not have been fully aware that at an earlier point in time he or she had the capacity to engage in SGA. Given the complexity of the medical evidence, and the imprecision often involved in selecting a specific cessation month, the application of a retroactive cessation date often appeared to operate unfairly against beneficiaries who, during the retroactive period, believed in good faith that their disability continued. In March 1982 the Commissioner of Social Security announced a change of position regarding the processing of title II and title XVI medical cessation cases. Under the change of position, the month of cessation in medical cessation cases generally will now coincide with the month in which the notice of the proposed cessation, i.e., the 10-day advance notice letter (title II cases) or The Notice of Planned Action (title XVI and concurrent title II/title XVI cases) is mailed to the individual. There are, however, exceptions to this rule which are described below.

Disability Cessations When a Retroactive Cessation Date May be Appropriate

A. Report of Earlier Medical Cessation

A beneficiary may report that at an earlier date he or she was informed by the treating physician that he or she had regained the capacity to return to work. In other cases, the treating physician may voluntarily report that the beneficiary was informed at an earlier date he or she had the capacity to return to work. Every beneficiary is furnished with the booklet "Your Social Security Rights and Responsibilities," which explains the individual's responsibilities for reporting a change in his or her medical condition. Therefore, when there is no doubt that the beneficiary was aware that he or she was able to work, but failed to timely report this change, a retroactive cessation will still be applicable. In these cases, cessation will be as of the month the individual was made aware he or she had regained the capacity to engage in SGA. However, a retroactive cessation date will not apply if there is a substantial conflict between statements from the treating physician and the beneficiary regarding the individual's awareness of the capacity to work or objective medical evidence to support the statement from the treating physician establishing a retroactive cessation date, is lacking or inadequate.

B. Return to Work in a Medically Diaried Case

In certain "clear-cut" cases, cessation may be found in a medically diaried case without current medical development as of the first month the beneficiary returned to full-time work with no significant medical restriction. The basis for the cessation is that the individual, by returning to full-time work, has clearly demonstrated that he or she does not have an impairment of sufficient severity to prevent SGA.

> *Example:*
>
> The evidence obtained during the initial case processing revealed that the individual had an impairment with marked functional restrictions which was expected to continue for more than 12 months. Recovery was expected approximately 18 months after onset of disability and a medical reexamination was established accordingly. Upon notice by the individual of a return to work, a CDI was initiated. The investigation disclosed that 16 months after onset the individual returned to full-time work. It also established that the individual's doctor approved this return to work without imposing any medical restrictions. Cessation based on capacity for SGA without addi-

tional development will be found in the month the individual returned to work. The finding of cessation will be based on the impairment not being severe rather than the work performed. Under the law, services rendered may not be used as the sole basis for termination until a trial work period (TWP) is completed.

Note: In no instance may a "clear-cut" cessation be made where the individual is receiving vocational rehabilitation (VR) services at the time of the CDI since participation in VR constitutes evidence inconsistent with such a determination.

In all cases where the evidence in the file is inconclusive (e.g., the individual is working part-time, alleges continuing disability, is receiving VR services or is working contrary to medical advice), the "clear-cut" cessation will not apply and medical development will be undertaken to resolve the issue of medical recovery. If the individual described in the example above had returned to part-time work, medical development would have to be undertaken because it is not clear that the individual has the capacity for full-time work. If medical development is required, a retroactive cessation will not apply.

If it is found that the individual is working despite a continued disabling impairment and such work is within the TWP, a finding of continuance will be made. In no instance will the work by itself be considered a basis for cessation until the expiration of the TWP as long as the impairment remains disabling.

C. Failure to Cooperate

There are instances when an individual, whose continuing disability is being investigated, fails to cooperate when asked to furnish necessary evidence or to appear for a physical or mental examination.

Cessation based on failure to submit evidence of continuation of disability as evidenced by an individual's failure to cooperate, is justified when (1) there is a continuing disability issue, (2) the disability issue cannot be resolved with the evidence of record, (3) efforts to have the beneficiary cooperate in obtaining the necessary evidence have been appropriate and complete but unsuccessful, and (4) the evidence indicates, that in spite of such efforts and without good cause, the beneficiary's failure to cooperate continues.

In these instances, disability will be found to have ceased in the month specified by SSA in the first written request made to the beneficiary indicating that unless he or she cooperated by a specified date, benefits might be terminated due to failure to submit evidence necessary for determining whether disability continues.

D. Whereabouts Unknown

There are instances when an individual cannot be located at the time of a CDI. In these cases, every reasonable effort will be made to locate the individual. However, if the individual still cannot be located, a determination of cessation of disability may be appropriate.

Cessation based on failure to submit evidence of continuance of disability as evidenced by an individual's whereabouts being unknown is justified when (1) a continuing disability determination is necessary, (2) a decision cannot be made on the basis of the medical and other evidence of record, and (3) following appropriate attempts to locate the beneficiary, his or her whereabouts remain unknown.

In these instances, disability will be found to have ceased effective with the first month in which there was knowledge that the beneficiary's whereabouts were unknown but no earlier than the month in which a continuing disability issue arose.

Note: In title XVI and concurrent title II/title XVI cases, benefit payments are suspended when a recipient's whereabouts are unknown. A title XVI determination will not be prepared and no recipient notification is required.

E. Failure to Follow Prescribed Treatment

An individual who fails without justifiable cause to follow treatment prescribed by a treating physician which can be expected to restore the individual's capacity to work, cannot by virtue of such failure be found to have a continuing disability.

Cessation based on failure to follow prescribed treatment is justified when (1) the evidence establishes that the individual's impairment precludes engaging in any SGA or, in the case of a disabled widow or widower, that the impairment meets or equals the Listing of Impairments, (2) treatment which is clearly expected to restore capacity to engage in SGA has been recommended by a treating physician, and (3) the evidence of record discloses that there has been refusal to follow prescribed treatment without justifiable cause.

In these instances, a finding of cessation will be made with the month in which the evidence clearly established the individual's unjustified failure to follow the prescribed treatment (see SSR 82-59 (PPS-78: Failure to Follow Prescribed Treatment).).

F. Work Activity Only

If medical recovery is not an issue and the beneficiary has engaged in work activity, a cessation will be found effective with the first month the beneficiary engages in SGA following completion of 9 months of trial work. If the beneficiary is not entitled to a TWP, cessation will be found effective with the first month the beneficiary engages in SGA.

Retroactive Cessations Involving Reopenings

Retroactive cessation determinations must not conflict with the rules of administrative finality. These rules impose certain time limits that SSA will follow in reopening and revising prior disability or continuing disability determinations or decisions which have become final, and that are explained in Regulations No. 4, sections 404.987-404.995 (title II), and Regulations No. 16, sections 416.1487-416.1494 (title XVI). They provide that an initial, reconsidered, or revised determination, or a decision or revised decision, that is otherwise final, may nevertheless be reopened:

- *Within 1 year* from the date of the notice of the initial determination, for any reason;
- *Within 2 years* from the date of the notice of the initial determination in a title XVI case, upon a finding of good cause;
- *Within 4 years* from the date of the notice of the initial determination in a title II case, upon a finding of good cause.

  ("Good cause" exists where new and material evidence is furnished after notice to the party of the determination or decision, or a clerical error was made, or there was an error on the face of the evidence on which the determination or decision was made. "New and material evidence" includes any evidence which was not part of the record when the final determination or decision was made, but which relates back to the date of the original determination or decision, and which shows facts that may result in a conclusion different from that originally reached had the new evidence been available at the time of the original determination.)

- *At any time* in a title XVI case if the determination or decision was obtained by fraud or similar fault, or *at any time* in a title II case under certain specified conditions including fraud or similar fault, or a clerical error or error on the face of the evidence on which the determination or decision was based *and the determination or decision was unfavorable to the claimant* in whole or in part.

Therefore, in a retroactive cessation situation, in the absence of fraud or similar fault, title II determinations or decisions that a person was under a disability during a certain period may only be reopened and revised to a finding that the person was not under a disability during that period under the 1-year or 4-year rule, and title XVI determinations or decisions may only be reopened and revised in this manner under the 1-year or 2-year rule. For example, if an initial title II determination was approved in September 1974 finding that a claimant was under a disability as of that date and the notice of this initial determination was sent October 3, 1974, and a continuing disability investigation was conducted in 1980 which resulted in new evidence on the claimant's employment in 1974, any determination of disability cessation which would result from this new evidence would be subject to the 4-year time limit for reopening that determination. In the cited case, the determination which was prepared on the basis of new evidence in 1980 could not reopen and revise the September 1974 determination, in the absence of fraud or similar fault. The earliest possible retroactive month of cessation would be October 1974.

Where administrative finality prevents reopening of a prior decision, cessation may be established as of any month after the prior decision in which new evidence establishes that the claimant was not disabled. However, the fact of cessation must be established by the new evidence, i.e., evidence that was not considered in making the prior determination. In establishing cessation after a prior determination, it is not necessary to find a change in the circumstances of the claimant's employment. For example, a title II determination of continuance was made and the notice sent in December 1975, following the completion of a TWP. New evidence provided by a December 1980 CDI showed that the claimant was working at an SGA level in January 1976 and that this work continued. It is not necessary to review the prior determination, or the facts supporting it, to see if there has been a change in the circumstances of employment.

However, even if the new evidence provided by the CDI in December 1980 showed that the prior determination was incorrect, e.g., that the claimant had performed the same SGA level work prior to January 1976 as he had from January 1976 on, the date of cessation would still be January 1976, because, under the 4-year reopening rule, a determination prepared in 1980 could not reopen and revise the December 1975 determination, in the absence of fraud or similar fault. If however, the new evidence provided by the CDI in December 1980 related only to the claimant's work in December 1975 or earlier, such a CDI could not be the basis for a finding of cessation in January 1976, or in any other month.

Redetermination is an evaluation of the title XVI factors of eligibility since the last determination or redetermination, e.g., residence and living arrangements, earned and unearned income, resources, etc. However, a CDI to evaluate disability/blindness is generally not undertaken, unless there is an issue of continuing disability/blindness. Therefore, the retroactive determination of disability/blindness cessation is not normally limited by the finality of a previous title XVI redetermination. The retroactivity of the date of cessation of disability will be limited only by the evidence in most cases. The rules of administrative finality affect the retroactivity only when there has been a redetermination decision that not only evaluated the nondisability factors of eligibility, but also included a determination on the disability/blindness factors of eligibility. Where such a redetermination established continuing disability/blindness eligibility, the date of cessation of disability cannot be established on or before the date of the redetermination, unless the redetermination decision can be reopened under the rules of administrative finality.

Example 1:

Mr. Wilson's application for Supplemental Security Income (SSI) was allowed on January 2, 1975, with the date of onset being established as of November 15, 1974, the date on which his application was filed. On April 10, 1980, the Social Security district office (DO) obtained evidence that Mr. Wilson's disability had ceased as of December 1975 by virtue of SGA. While there had been intervening redeterminations of eligibility and/or payment amount, there had been no intervening determination of continuing disability/blindness. Therefore, the DO prepared a determination ceasing Mr. Wilson's disability as of December 1975, and terminating title XVI eligibility as of the last day of February 1976.

Example 2:

Mr. Watson's disability was established for title XVI purposes with a date of onset of November 15, 1974, the date on which his application was filed. In December 1975, Mr. Watson reported that he had returned to work as of February 1975. On February 15, 1976, the DO prepared a determination that a TWP had been completed but the work was not SGA and his disability was continuing. A title XVI continuance letter was released to the claimant on March 1, 1976.

On April 10, 1980, the DO obtained new and material evidence that since December 1975, Mr. Watson's activity was SGA. In this case, while the retroactivity of the date of cessation was not limited by the intervening redeterminations of eligibility and/or payment amount, retroactivity was limited by a previous determination of continuance which could not be reopened under title XVI rules of administrative finality because the notice of this initial determination of continuance which could not be reopened under title XVI rules of administrative finality because the notice of this initial determination of continuance had been sent more than 2 years before. The retroactive date of cessation was therefore limited to a date subsequent to the date of the prior determination of February 15, 1976, and the DO prepared a determination ceasing Mr. Watson's disability as of March 1976, and terminating title XVI eligibility as of the last day of May 1976.

EFFECTIVE DATE: The policies covered by this Program Policy Statement have been in effect for many years except for the policy to have the month of cessation in a majority of medical cessation cases coincide with the month in which the 10-day advance notice letter (title II cases) or the Notice of Planned Action (title XVI and concurrent title II/title XVI cases) is mailed to the individual. This change of position became effective in March 1982.

CROSS-REFERENCES: Program Operations Manual System Part 4, Chapter 2, and Part 04, Chapter 005, Subchapter 04.

TITLES II AND XVI: EXTENSION OF ELIGIBILITY FOR BENEFITS BASED ON DISABILITY

PURPOSE: To state the policy on when eligibility for benefits based on disability may be extended after completion of the 9-month trial work period (TWP).

CITATIONS (AUTHORITY): Sections 202(d)(1)(G), 202(e)(1), 202(f)(1), 216(i)(2)(D), 222(c)(1), 222(c)(3), 223, 223(a)(1), 226(b), 1611(e), 1614(a)(3), and 1614(a)(3)(D), of the Social Security Act, as amended.

PERTINENT HISTORY: To encourage disabled persons to attempt to work, Congress enacted the 1980 Amendments (Public Law 96-265). The amendments provide an extended period of eligibility, under titles II and XVI, to persons who complete 9 months of trial work and continue to have a disabling impairment. The extended period begins with the month immediately following completion of the 9th month of trial work. It continues for 15 consecutive months and then ends with the month preceding the termination month. In most cases the termination month is the first month of substantial gainful activity (SGA) after the 15-month period. In some title II cases the termination month is the third month after the first month of SGA after the 15-month period. (Examples are provided in the text to illustrate these policies.) If a person's payments stop because disability has ceased due to work activity, and subsequently, but within the extended period, his or her earnings fall below SGA, he or she is reentitled to benefits. A new application and disability determination are not required to reinstate payments in these cases.

The amendments do not change the definition of disability. Persons will continue to be eligible for payments as long as they continue to meet the definition of disability. The amendments do not limit the payment of disability benefits after disability ceases. A person whose disability ceases will still be eligible for payments for the month of cessation and 2 additional months. The main effect of the amendments is that they permit the reinstatement of benefits to persons whose disability payments stop because of their work activity after 9 months of trial work. If such persons continue to have a disabling impairment and their work attempt fails within the extended period, payments can again be made.

POLICY STATEMENT: The amendments described above are applicable to persons whose disability has not ended before December 1, 1980. Where a determination is made after December 1, 1980, that a person's disability ended before that date, such a person would not be covered by the new amendments. Counting of the 15-month period will not begin earlier than December 1980, even if the TWP ended before December 1980 and disability continues.

When the Extended Period of Eligibility Does Not Apply

The extended period of eligibility does not apply to:

1. Persons whose disability ended before December 1, 1980;
2. Persons whose disability has been determined to have medically ceased;
3. Persons who are not entitled to a TWP, e.g., title II disabled worker beneficiaries who do not serve a waiting period and persons receiving title XVI payments on the basis of blindness;
4. Persons who do not complete a full 9-month TWP; and
5. Persons who have already received an extended period of eligibility. (Since a person is entitled to no more than one TWP in a period of disability (title II), or a period of eligibility based on disability (title XVI), a person can receive no more than one extended period of eligibility.)

Duration of the Extended Period of Eligibility

Under titles II and XVI the extended period of eligibility begins with the month immediately following completion of the 9th month of trial work.

For title II beneficiaries it ends with the earlier of:

1. The second month following the month in which the person's impairment is not disabling; or
2. The second month following the earliest month in which the person engages in SGA or is able to do so, but not earlier than the month preceding the first month of SGA after a period of 15 consecutive months following the 9th month of trial work.

Example 1:

Tom Jones completes the TWP in December 1980. He is then working at an SGA level and continues to do so throughout the 15-month extended period and thereafter. The extended period ends with March 1982. This is the 15th month after completion of the 9-month TWP and is the month before the first month of SGA after the 15-month period.

Example 2:

Mary Smith completes the TWP in December 1980. She does not begin to engage in SGA until December 1982 (24 months after the TWP). The extended period of eligibility ends with February 1983, i.e., the second month following the first month of SGA after the TWP.

For title XVI recipients the extended period of eligibility ends with the earlier of:

1. The month preceding the month in which the person's impairment is not disabling; or

2. The month preceding the first month a person engages in SGA or is able to do so after a period of 15 consecutive months following the 9th month of trial work.

Example 1:

John Smith completes the TWP in December 1980. He does not begin to engage in SGA until December 1982 (24 months after the TWP). The extended period ends November 1982, i.e., the month preceding the first month of SGA after 15 consecutive months following the TWP.

Example 2:

Mary Jones completes the TWP in December 1980. She is then working at an SGA level and continues to do so throughout the 15-month period. The extended period ends with March 1982. This is the 15th month after completion of the TWP and the month preceding the first month of SGA after completion of the 15-month extended eligibility period.

The extended period of eligibility could last indefinitely. If the individual with a disabling impairment never engages in SGA, his or her extended period of eligibility never ends. However, reinstatement of payments can occur only within 16 months following the 9th month of trial work. If the individual's work failure does not occur until after 16 months following the 9th month of trial work, he or she would have engaged in SGA in the 16th month and thus his or her extended period of eligibility would have ended.

Payment of Disability Benefits During the Extended Period of Eligibility

Although there are technical differences between the title II provisions and the title XVI provisions, the effect is essentially the same under each title. Persons who complete 9 months of trial work and continue to have a disabling impairment can be paid for the month of cessation and the 2 succeeding months and for any additional months within the extended period in which they do not perform SGA. The differences between the payment provisions of each title are summarized as follows:

1. Title II

   The amendments provide that eligibility for payments continues throughout the extended period but that no benefit shall be payable to a person for any month of SGA after the second month following the month of cessation.

2. Title XVI

   The amendments provide that eligibility for section 1611 disability payments continues throughout the extended period but that no benefit shall be payable to a person for any month of SGA after the second month following the month in which disability ceases. Thus, where a title XVI recipient

> receiving disability payments under section 1611 does not begin to engage in SGA until more than 15 months after completing a 9-month TWP, his extended period of eligibility ends with the month preceding the SGA month. The individual is still eligible for section 1611 disability payments for the month of cessation (the first month of SGA) and the following 2 months.
>
> Section 1611 payments are those made to a person whose disability has not ceased. Where payments cannot be made under section 1611 of the Social Security Act because of SGA, the individual may still qualify for a special payment under section 1619 of the 1980 amendments if he or she continues to have a disabling impairment.

The Title II Period of Disability (Freeze)

The amendments change the ending date of the period of disability (freeze) in some cases for persons who complete 9 months of trial work. The period of disability ends with the last month for which disability benefits are payable. For persons who complete 9 months of trial work and continue to perform SGA, the period of disability ends the second month after the month of cessation as under the law prior to the amendments.

> *Example:*
>
> John Smith completes a 9-month TWP in December 1981. A work activity continuing disability investigation (CDI) is made in January 1982. John is then engaging in SGA and has demonstrated the ability to do so. Assuming that John continues to perform SGA, he would receive payments for January 1982, February 1982, and March 1982. His extended period of eligibility which began in January 1982 would end with March 1983, the month preceding the first month of SGA after the 15-month period. However, his period of disability would end with March 1982. This is the last month for which disability benefits were payable.

For those who complete 9 months of trial work, and whose disability ceases but whose payments are later reinstated, the period of disability ends with the last month for which disability payments are made.

> *Example:*
>
> Assume the same facts as in the example above except that John stopped SGA in January 1983 and did not return to SGA again until June 1983. Then the last month of payment would be May 1983 and this would be the ending date for the period of disability.

If it is determined that a person's impairment is no longer disabling at some time after the individual completes 9 months of trial work, the period of disability will end with the earlier of the following:

1. The second month after the month the impairment is not disabling.

   Example:

   Harold Johnson completed a TWP in December 1981 and did not engage in SGA. A CDI was initiated which revealed he no longer had a disabling impairment as of April 1982. Harold's period of disability ended in June 1982, the second month after the month the impairment was no longer disabling.

2. The last month of payment based on the SGA.

   Example:

   Bill Jones completed a TWP in December 1980 and did not engage in SGA until July 1981 at which time a cessation determination was prepared. He did not perform SGA in August 1981 and September 1981 but returned to gainful employment in October 1981. SSA determined that impairment severity ceased in August 1981. Bill's benefits continued through September 1981, i.e., for the month of cessation and 2 additional months. His period of disability ended with September 1981.

Requirement that a Person Must Continue to Have a Disabling Impairment

The 1980 amendments introduced a new concept in continuing disability adjudication. To qualify for the extended period of eligibility, a person must continue to have a disabling impairment. Cases in which a person appears to qualify for the extended period of eligibility will be evaluated to determine whether the person continues to have a disabling impairment even when "disability" previously has ceased because of SGA.

In addition to the usual events which raise a medical continuing disability issue, special criteria have been developed for identifying cases in which the issue may exist.

The issue of whether a person continues to have a disabling impairment could arise at any time, i.e., before a person completes 9 months of trial work, after the 9-month TWP but before the person engages in SGA, and even after disability has ceased because of performance of SGA, the issue could arise before the close of the extended period of eligibility or afterwards.

When a continuing disability determination is made that the person's impairment is not disabling, Medicare and eligibility for the special benefits of title XVI and XIX ends. When it is determined that the month in which the impairment is not disabling is before the first month of SGA, disability ceases. The disability case will be processed in the usual manner. The extended period of eligibility also ceases. When it is determined that the month in which the impairment is not disabling coincides with or is after the first month of SGA but within the extended period of eligibility, the effect of such a determination is to terminate the extended period of eligibility, cash benefits and other work incentive benefits. However, when the month in which the impairment is not disabling occurs after the extended period and the individual is not in payment status, the determination affects only Medicare and the special benefits under titles XVI and XIX.

When a person has been found disabled, he or she is presumed to continue to have a disabling impairment until a formal determination is made (with notification and appeal rights) that his or her impairment is no longer disabling.

Reinstatement of Disability Benefits

When a person's earnings fall below SGA (regardless of the reason) within the extended period of eligibility, he or she is reentitled to benefits. Title II and section 1611 disability payments can be reinstated provided that the person continues to have a disabling impairment. The reinstatement of disability payments is effective with the first month of non-SGA. Payments continue throughout the extended period, subject to the rule that no disability benefit shall be payable for any month of SGA after the second month following the month of cessation. Payments may continue until the first month of SGA after the 15-month period or until the third month following the month in which the impairment is not disabling, whichever is earlier.

Return to SGA after Reinstatement

When an individual returns to SGA after the 15-month period, eligibility for title II payments and section 1611 title XVI payments ends.

EFFECTIVE DATE: On publication.

CROSS-REFERENCES: Program Operations Manual System, section DI 00504.180.

TITLE II: INCLUSION OF INCREASES IN WORKERS' COMPENSATION AND CERTAIN OTHER PUBLIC DISABILITY BENEFITS IN COMPUTING OFFSET

PURPOSE: To state the policy regarding the treatment of increases in workers' compensation (WC) and certain other disability benefits provided under Federal, State, or local laws or plans (hereafter collectively referred to as "public disability benefits").

CITATIONS (AUTHORITY): Section 224 of the Social Security Act (the Act), Regulations No. 4, section 404.408.

PERTINENT HISTORY: Section 224(a) of the Act provides that when a disability insurance (DI) beneficiary under age 65 also receives public disability benefits, the disability insurance benefit (DIB) may be reduced. The total of benefits the beneficiary and his or her family receive under all programs is not to exceed the higher of 80 percent of his or her average predisability current earnings or the maximum family benefits payable on the basis of his or her earnings.[1]

Clauses (7) and (8) of section 224(a) of the Act provide a specific exception to that provision. They allow Social Security benefit increases to be passed on to the beneficiary by precluding any subsequent monthly offset from reducing the Social Security benefit below the sum of the reduced benefit for the first month of offset and any subsequent increases in Social Security benefits. However, there is no corresponding provision which would allow increases in the public disability benefit to be passed on to the beneficiary. Moreover, the legislative history of the offset provision indicates that Congress was not considering potential increases in the public disability (then workers' compensation) benefit when it drafted sections 224(a)(7) and (8).

The history reveals that Congress envisioned two methods by which reduced benefits would be protected against inflation. First, increases in the Federal benefit would be protected pursuant to sections 224(a)(7) and (8). Second, the worker's average predisability earnings would be recalculated, on a triennial basis, to reflect changes in its value. There is no indication in the legislative history that Congress believed the additional protection of increases in public disability benefits would be required to prevent the erosion of the worker's benefits. Although section 224(a)(7) and (8) of the Act and section 404.408(a) of the regulations provide that increases in DI benefits after offset is imposed are not subject to offset, the Act and regulations do not specifically cover the treatment of increases in the amount of public disability benefits.

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[1] Prior to September 1981 section 224 only provided for the offset of WC benefits before age 62. Section 2208 of Public Law 97-35 (the Omnibus Budget Reconciliation Act) enacted in 1981 modified section 224 to provide that certain other public disability benefits are to be offset the same as WC and that the reduction could be imposed up to age 65.

Section 224 of the Act or section 404.408(a) of the regulations, thus, does not authorize limiting offset to the first monthly amount of public disability benefits. In fact, the legislative purpose as indicated by the statute and legislative history, is clearly contrary to that result. To apply offset on the basis of the first such award, reducing the excess over the 80 percent limitation, and then not readjusting on the basis of a later, increased award, would result in combined benefits that could substantially exceed the 80 percent limitation set forth in section 224(a)(1-6). The resulting payment of combined benefits in excess of predisability earnings was specifically disapproved in the original legislative history of the offset provision and has been subsequently reaffirmed by Congress.

Additionally, the language of section 224(a) of the Act provides for the reduction of DI benefits for those *months* in which the individual is entitled to both DI benefits and other public disability benefits (including WC). In other words, benefits are computed monthly and increases or decreases in the amount of benefits received for any month require a corresponding adjustment in offset for that month. Both the language of 224(a) of the Act and section 404.408 of the regulations call, therefore, for the monthly computation of benefits and possible ensuing reductions based on the amount of public disability benefit payable for each month.

POLICY STATEMENT: All increases in public disability benefits after offset is first considered or imposed should be considered in the computation of the DIB reduction and will result in the imposition of an additional offset where appropriate. Although this issue was not specifically addressed in section 224 of the Act, it is consistent with the intent of Congress to limit combined public disability benefits and DIB.

Each subsequent increase in the public disability benefit after offset is imposed may result in a further reduction of Federal disability benefits. Where offset was previously considered but not imposed because the combination of public disability benefits and DIB did not exceed the 80 percent limit (or total family Social Security benefit, where applicable) such increases in the public disability benefit could, of course, result in the initial imposition of offset. This policy is comparable to the Social Security Administration's treatment of decreases in the public disability benefit. Where the DIB is reduced because of the receipt of the public disability benefit and the public disability benefit decreases, the DIB is increased, subject to the maximum payable, to the limit specified in section 224.

EFFECTIVE DATE: This policy has been in effect for many years.

CROSS-REFERENCES: Program Operations Manual System section DI 00203.345.

(Previously Published as PPS-70) **SSR 82-69**

TITLE XVI: EXCESS PAYMENT AS A PREREQUISITE FOR THE IMPOSITION OF A PENALTY DEDUCTION UNDER SECTION 1631(e) (2)

PURPOSE: To make explicit the policy of the Social Security Administration (SSA) regarding the conditions under which a penalty deduction will be imposed against a recipient of Supplemental Security Income (SSI) payments.

CITATIONS: Section 1631(e) (2) of the Social Security Act; Regulations No. 16 sections 416.722-416.732.

PERTINENT HISTORY: Section 1631(e) (2) provides that a penalty will be imposed whenever a recipient of SSI payments fails to submit, or delays in submitting, a required report of events and changes in circumstances which affect eligibility for or amount of benefits under title XVI. Regulations No. 16, section 416.722(a) through (d), states that a penalty deduction will be imposed if the recipient fails to make a required report on time without good cause, and SSA must reduce, suspend, or terminate benefits because of the event not reported, and the recipient received and accepted an SSI benefit for the penalty period.

When a recipient fails to report, or delays in reporting, an event or change in circumstances which would cause a reduction, suspension, or termination of his/her SSI payments, SSA continues to pay the incorrect benefits until the Agency becomes aware of the event or change, and receives sufficient information to determine continued eligibility or payment amount.

This improper continuation of payments creates an excess payment to the delinquent recipient. An excess payment is the amount of money paid in excess of the amount the recipient was actually eligible to receive during the period in question. An excess payment must occur before a penalty deduction can be imposed; it is, as such, a necessary condition for the imposition of a penalty.

It should be noted that SSA's operating guidelines have interpreted the penalty provisions of the Act and the regulations in this manner since the enactment of those provisions.

POLICY STATMENT: In the absence of a finding of without fault or good cause, SSA will impose a penalty deduction against a recipient who fails or delays in reporting an event which would cause a reduction, suspension, or termination of SSI benefits when that failure or delay causes the Agency to make an excess payment to the recipient responsible for making the delinquent report.

CROSS-REFERENCES: Program Operations Manual System Part 05, Chapter 023, Subchapter 01 (SI 02301.500-SI 02301.525).

Part II
Changes in Law and Regulations

REGULATIONS **SSR 82-II-II**

The following amendments and additions under title II and XVI of the Social Security Act have been published in the Federal Register:

A. REGULATIONS NO. 4—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE (20 CFR PART 404).

1. Subpart C—Amendments to this subpart were published in the Federal Register (47 FR 30731) on July 15, 1982.

   Revised and reorganized the rules on basic computations of primary insurance amounts to make the rules clearer and easier to use. Also added new rules on how to compute benefit computation dropout years for disabled workers.

2. Subpart D, J, and P—Amendments to these subparts were published in the Federal Register (47 FR 31539) on July 21, 1982.

   Revised regulations to provide, in certain cases, a disabled person who has medically recovered will not have his or her benefits terminated if participating in an approved vocational rehabilitation program under a State approved plan.

3. Subpart U—Amendments to this subpart were published in the Federal Register (47 FR 30468) on July 14, 1982.

   Reorganized and restated regulations on representative payment under titles II and XVI. The regulations 1) explain representative payment; 2) state when benefits will be paid to a representative payee rather than directly to the entitled person; 3) indicate the procedure followed in selecting a representative payee; 4) specify the responsibilities of a representative payee; and 5) clarify Social Security's responsibilities to the beneficiary when payment is made to a representative payee on his or her behalf.

B. REGULATIONS NO. 16—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED (20 CFR PART 416).

1. Subpart F—Amendments to this subpart were published in the Federal Register (47 FR 30468) on July 14, 1982.

   See item A-3 above for description of changes.

2. Subparts M and N—Amendments to these subparts were published in the Federal Register (47 FR 31539) on July 21, 1982.

   See item A-2 above for description of changes.

Part III
Items of General Interest

New and Revised Pamphlets SSR 82-III-I

The following new and revised booklets and pamphlets explaining various aspects of the retirement, survivors, disability, and supplemental security income provisions of the Social Security Act, as amended, and of the black lung provisions, have become available for distribution. Single copies of these and other leaflets and booklets are available without cost at any Social Security office. Information on quantity purchases may be obtained from that office or from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

1. ANSWERS FOR DOCTORS. SSA Pub. No. 05-10013, June 1982.

   Revised leaflet giving highlights of the Social Security disability program: Who is eligible; basic requirements; and how decisions are made on disability claims.

2. IF YOU BECOME DISABLED. SSA Pub. No. 05-10029, May 1982.

   A revision of the booklet explaining the requirements for disability benefits, how to apply, and how a decision is made. It highlights some things a disabled person needs to know when a claim is approved and tells how a decision can be appealed.

3. THINKING ABOUT RETIRING? SSA Pub. No. 05-10055, July 1982.

   A leaflet which answers many questions about Social Security and retirement. Aids in planning retirement.

4. FOR THE YOUNG WORKER—SOCIAL SECURITY. SSA Pub. No. 05-10063, July 1982.

A leaflet designed for young people briefly explaining the basic protections provided by Social Security.

5. ESTIMATING YOUR SOCIAL SECURITY RETIREMENT CHECK—FOR WORKERS WHO REACH 62 IN 1979-83. SSA Pub. No. 05-10088, June 1982.

   A leaflet which can give you a rough estimate, *not an exact figure*, of what your retirement check will be.

6. SOCIAL SECURITY BENEFITS—LET'S TALK DOLLARS AND SENSE—FOR STATE AND LOCAL GROUPS. SSA Pub. No. 05-10108, July 1982.

   This leaflet presents examples of the monthly Social Security benefits payable when a State worker becomes disabled, dies, or retires.

7. A WOMAN'S GUIDE TO SOCIAL SECURITY. SSA Pub. No. 05-10127, May 1982.

   A booklet which is a guide to those Social Security provisions that are, or can be, of particular interest to women.

8. SSI FOR AGED, DISABLED, AND BLIND PEOPLE. SSA Pub. No. 05-11000, June 1982.

   This leaflet briefly explains the SSI program and tells you how to apply for payments if you think you can qualify. It also tells you about other help you may be able to get.

9. REPORTING CHANGES THAT AFFECT YOUR GOLD SSI CHECKS. SSA Pub. No. 05-11053, July 1982.

   A leaflet which explains some of the things which must be reported and how to report them.

10. A GUIDE TO SUPPLEMENTAL SECURITY INCOME. SSA Pub. No. 05-11015, July 1982.

    A booklet designed to assist groups and organizations who have contact with potential or present SSI recipients. It describes the SSI program in detail.

Rulings Obsoleted, Superseded or Rescinded 82-III-II

The following Rulings have been declared obsoleted, superseded, or rescinded. A cumulative listing of all obsolete rulings from 1960 on is published annually in the "Cumulative Edition."

Past Ruling	Current Status
61-10	Superseded by SSR 81-39
62-45	Obsoleted without replacement
63-11c	Obsoleted without replacement
63-14	Rescinded
64-46c	Obsoleted without replacement
73-23c	Obsoleted without replacement
73-59c	Obsoleted without replacement
74-7c	Obsoleted without replacement
79-32c	Obsoleted without replacement
81-3c	Superseded by SSR 82-58

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All issues available have been filmed. Unfortunately, any scattered missing issues are no longer available.